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FROM HEALTH TO WELFARE. FEDERAL GOVERNMENT POLICIES REGARDING STANDARDS OF PUBLIC HEALTH FOR CANADIANS, 1919-1945.

by

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A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE
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DEPARTMENT OF HISTORY

EDMONTON, ALBERTA
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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "From Health to Welfare. Federal Government Policies Regarding Standards of Public Health for Canadians, 1919-1945," submitted by Janice P. Dickin McGinnis in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

The Canadian federal Department of Health was established in 1919 as an answer to reform demands stemming out of the First World War. It was to handle some specific problems and to co-ordinate health activities for the country. Its inability to fulfil its mandate was due in large part to insufficient funds and confused jurisdiction. During its first decade of existence, it concerned itself mostly with health matters, generally to do with quarantine, it had inherited from other departments and with campaigns against narcotics and venereal disease. Other reform demands--to do with child welfare, housing, hospitalization, public health engineering, medical research and pollution--received less attention, the Department's handling of these items never going much beyond the release of publicity and the production of information. In 1928, the Department was coupled with the Department of Soldiers' Re-establishment. Demands for health reforms were not so fervid as they had been a decade before and in the intervening period, Health had failed to establish a firm base for itself. The new Department of Pensions and National Health concerned itself mostly with care-taking duties.

During the Depression there were again calls for leadership in the field of health. High levels of unemployment meant that Canadians were denied all but the most necessary medical care, were unable to pay for care they did receive, and were subject to deteriorating physical conditions due to destitution. Demands were made on the federal

government, in health as in other concerns, to make up the short-fall. The Dominion was reluctant to shoulder duties that would certainly be expensive, possibly long-term and probably outside the realm of its constitutional obligations. But although federal health activities were cut back at the beginning of the decade, by the end the Department was studying various reforms, notably health insurance. Before the Department had taken any momentous steps, another war once again made national health a high priority.

The Second World War placed extra demands upon the health branch of Pensions and National Health. However, despite the reinvigoration, most of the new activities were in the nature of short-term measures to get Canada through the war rather than long-term schemes for general betterment of the nation's health. The major exception was the Department's study of health insurance, meant to jibe with other forms of social insurance being considered as reforms for the post-war period. It was hoped that such insurance would provide for a high standard of health by providing individual Canadians with the means to purchase needed medical care. A concomitant system of grants would also be made to increase the supply of facilities and personnel.

Health insurance failed to gain acceptance for many reasons but, most importantly, because it was felt that the old health needs could be partly provided for within the context of the new welfare schemes. Federal concerns in both these fields were to be handled by the new Department of National Health and Welfare instituted in 1944.

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ABBREVIATIONS

BMS	Baker Memorial Sanatorium
CJEPS	*Canadian Journal of Economics and Political Science*
CMA	Canadian Medical Association
CMAJ	*Canadian Medical Association Journal*
CNA	Canadian Nurses' Association
CPHA	Canadian Public Health Association
CPHJ	*Canadian Public Health Journal*
DBS	Dominion Bureau of Statistics
DCH	Dominion Council of Health
NHW	Department of National Health and Welfare
OMA	Ontario Medical Association
PAA	Provincial Archives of Alberta
PAC	Public Archives of Canada
PNH	Department of Pensions and National Health
SCR	Department of Soldiers' Civil Re-establishment

> Public health is purchaseable and within limits the community can determine its own death rate.
> --Motto of the New York Board of Health, quoted by Robert J. Manion in the House of Commons, 4 April 1919.

INTRODUCTION

At the end of the Great War, Canadians began to consider some sobering thoughts about their national standard of health. Some of the reasons for increased concern can be laid at the door of the general reformism of the period evidenced in many western nations, but specific problems within the country itself cannot be ignored. The patriotic legend that Canada had the healthiest of all climates was simply not supported by the evidence. Over one half of all would-be recruits had been rejected as unfit for military service. Between 1914 and 1918, the country lost almost as many people from tuberculosis as it did from the fortunes of war. The influenza epidemic had taken about as many again and the failure of national, provincial and municipal health facilities to deal adequately with the flu did not bode well for the successful battling of the epidemic of venereal disease that was expected to arrive home with the troops. To replace the population that was dead, dying, sick or expected soon to enter one of these unenviable states, children would have to be borne and immigrants imported. But Canada had a shameful infant mortality rate and immigrants were seen as a potentially dangerous alternative, bringing disease--including feeble-mindedness--with them. The perceived needs were better medical care, more medical research, isolation of contagious diseases and border quarantine against all suspect immigrants. To provide for these the country could boast precisely one separate provincial department of public health. In all provinces but New Brunswick and in the federal government itself health matters were strewn among various incoherent divisions and departments. The federal attempt to introduce order into this chaos was the establishment of the Department of Health in 1919.

By 1928, the experiment was an unacknowledged failure. The solutions the federal department had applied--basically information, advice and very limited funds--could not begin to cover even the basics. By virtue of almost all the experts' reading of the British North America Act, prime responsibility for health resided with the provinces. To coordinate within their own and with each other's territories, they needed adequate funding. This was not forthcoming. In addition, there were health problems that could never be dealt with effectively within the traditional framework. The infant and maternal mortality rates could be lowered only so far by increased medical care. What was really needed were better housing and nutrition, better sanitation and shorter working hours for pregnant and nursing women. Tuberculosis could be treated within government-supported institutions but prevention required better living and working conditions. Even diseases that had succumbed years before to scientific methods of prevention and treatment were not handled successfully--the Canadian venereal disease campaign was crippled due to chronic lack of funds and typhoid fever, which could be eliminated by known methods of purification of water and pasteurization of milk, reappeared with embarrassing persistence.

The reaction of the federal department to its own failure was simply to keep doing what it had been doing, often at a decreased rate. Hiding behind its defined role as the organ in charge of prevention rather than treatment (the responsibility of the provinces), it managed the steadily decreasing VD grants; churned out literature on child care, sanitation and hospitalization; provided care of sick mariners; ran lab checks on food, proprietary and patent medicines, and on specimens of bacilli; kept an eye on health conditions on federal public works projects; ran its two leper colonies; policed the illicit use of narcotics; and ran a close check on drinking water on Great Lakes vessels to forestall outbreaks of typhoid. The only major piece of reform that occurred in the 1920s was an upgrading of the Immigration Medical Service and this can be interpreted as a negative approach. To ensure a better standard of health for Canadians, all immigrants were, for the first time, given a meaningful medical exam before setting foot on ship. In this way, Canada was expected to have less sickness--both of the chronic type the immigrants would keep to themselves and of the contagious type they would supposedly spread.

Really the only people whose health the federal government was actually concerned with caring for in an active manner were the veterans of the Great War. It was therefore not surprising that Health should be subsumed under the Department of Soldiers' Civil Re-establishment. The new joint department was given two deputy ministers and a double-barrelled title--Pensions and National Health. The denigration of the old Health Department implied in the new name was no accident. From the first, Pensions had a significantly larger budget than did National Health. It was not so much that Health had been demoted; it had simply never grown. Linking it with the decreasingly important Soldiers' Civil

Re-establishment--an organ of the government expected to die out at at least the same rate as the war veterans--indicated that hopes for growth had been abandoned.

If any illusions were left about possibilities of imminent revival of the moribund department, these vanished with the Depression. Divisions were lopped off--child welfare being transferred to the Council on Child and Family Welfare by 1934 and venereal disease control disappearing by 1935, three years after the federal government had cut off all grants to aid the provinces in running their clinics. The year 1935, however, was the watershed--not only for the federal health department but for all organizations concerned with social welfare. R. B. Bennett's so-called New Deal election platform of that year showed just how far acceptance of the need for some guarantee of a certain minimum level of social security had gone. By the last half of the decade, the first of a series of reports appeared on the state of the nation's health, and proposals for medical care were included in studies on social security in general. Two provinces, Alberta and British Columbia, went so far as to legislate health insurance plans. Federally, the Department had child welfare returned to it in 1937 and that same year epidemiology and nutrition were added. Divisions of industrial hygiene and of publicity and health education appeared in 1938. World War II made further health reform both necessary and possible. Needed recruits were once again being turned away for remediable physical defects; increased federal government spending and control did not meet the challenges in wartime that they had in peace. All the health divisions took on heavier duties; VD control was reinvigorated and nutrition and physical fitness were objects of new initiative. But the federal government's most ambitious health scheme was a plan to provide health insurance to all Canadians as soon as hostilities ceased.

Such a scheme was desirable for some basic reasons. Medical care had not been a large part of Depression relief provisions. As a consequence, people went sick and doctors went hungry. In more remote areas of the nation, medical facilities and personnel were just plain inadequate for a minimum standard of health care. Health insurance was meant to be a mechanism whereby sufficient money could be put into the hands of the consumers to pay for necessary medical services. Premiums were to be paid by employees and employers and government subsidies would be voted to provide for indigents. Several benefits were expected: the population would grow by the preferred method of natural increase; workers would be in better health longer, meaning less cost to industry for lost work days and less cost to government for the unemployed sick and their dependents; dependable funding would allow for a more rational and settled health network allowing Canada to combat effectively any expected post-war epidemic; health care as part of a general system of social security would help stave off any post-war revolutionary tremors; and, not least, income security would be guaranteed to some extent for health workers in general and physicians in particular.

An Advisory Committee on Health Insurance was established by Order in Council, 5 February 1942. Its draft proposal was released 16 March 1943, on the same day as Leonard Marsh's report on Social Security. After further study by the House of Commons Special Committee on Social Security, the health insurance scheme was taken before the Dominion-Provincial Conference on Reconstruction. It died there in the spring of 1946. Its passing was memorialized by the establishment of yet another departmental division, the Directorate of Health Insurance Studies.

The failure of the federal health insurance scheme can be chalked up to more than one account. Partly it fell from its own weight. Drawn up by doctors in the Department, aided generously by often unsolicited advice from the Canadian Medical Association, the scheme was long on payment of doctors' salaries and short on provision of hospitalization and laboratory services. It was also vague as to what the final cost would be and even provided for funds to take advantage of services that could not be provided. But the scheme also failed to be accepted for reasons other than its lack of quality. The infirmities of Canadian health care could not be cured by so one-dimensional a reform as health insurance. Simply pumping money into the medical care network would not straighten out all the kinks. There were too many complications in the areas of political and professional relations.

Health reforms could not be properly dealt with until the department had solved the problems that had plagued it since inception. Firstly, the provinces and municipalities were to provide medical care, the dominions to provide for public health. It is just possible that these two aspects could be seen as separable in 1867 but they certainly were not by the mid-twentieth century. Secondly, public health officials were to deal with prevention and the medical profession with treatment. It had been difficult to stick by this arbitrary division in disease control since the establishment of the germ theory--it was impossible by 1945. And thirdly, some health problems simply are not amenable to medical treatment. Malnutrition, industrial disease, and the ailments to do with poor sanitation and housing cannot be solved by a government-paid trip to the doctor. These are problems not of health but of welfare. The Canadian government introduced its Department of National Health and Welfare in 1944. It would attempt to find new solutions to old problems.

> There probably is nothing like a war to discover the steps that should be taken for the protection of public health.
> --Senator James Lougheed in the Senate, 1 May 1919.

Chapter One

"REPLACING THE CANNON FODDER"

ESTABLISHMENT OF THE DEPARTMENT OF HEALTH

One of the ironies of a physical checkup is that it may reveal defects that one functioned adequately without knowing about. However, once failings are discovered and identified by name, some form of physic seems called for. In a way, this is what happened to Canada at the time of the Great War. Males examined for fitness to fight in the lines were the first significant group of Canadians to have their physical lacks exposed to public perusal. Records were not kept for the first years but of 361,695 of what was supposedly the cream of Canadian manhood examined under the Military Service Act in 1917-18, 181,225 were declared physically unfit for active service, mostly for preventable defects.[1] This statistic was a direct blow to the patriotic myth of the invigorating Canadian climate. Senator James Lougheed, Minister of the Department of Soldiers' Civil Re-establishment, rose in the Senate to call the high number of rejections "a lamentable state of affairs to exist in a country whose people, owing to its climatic and other conditions, should be superior in physique to those of almost any other country."[2] But the military rejections were really just the most-publicized example of Canada's low standard of health. Various reformers had been pushing for varying lengths of time for the establishment of a department of health to coordinate action regarding four additional concerns--venereal disease, tuberculosis, infant mortality and feeblemindedness.

In a pamphlet issued by the National Council of Women in June 1917, Jennie E. Smillie, the convener of the public health committee, warned that "we must be prepared for the end of the war, when the return of the army will inevitably increase the danger of contagion from venereal diseases."[3] Overseas alone, the Canadian army recorded 66,083 cases of VD.[4] Together, syphilis and gonorrhea accounted for 12 percent of all sickness, exclusive of wounds.[5] In reality, this rate was probably not much different from that of the general Canadian population. A survey of all new admissions to the Toronto General Hospital in 1917 yielded a rate for syphilis alone of 12.8 percent.[6] However, the statistic among the armed forces seemed more shocking, in much the same way as the number of rejections had been. The so-called Wassermann test, the first effective diagnostic test for syphilis, had only been perfected in 1906. The armies of the Great War were the first significant groups of people to have the Wassermann applied to them. Without this progress, the extent of the problem would not have been known nor its seriousness apparent. But the problem was known and known to be serious. The Canadian army worked hard to prevent infection of the soldiers overseas, even though it claimed 25 percent of them had previously contracted their infections in Canada.[7] It pressured the authorities in France to remove "practically every infected woman" from the region of the lines[8] and the authorities in England, where most men picked up their cases of VD while on leave, to control "the woman side of the question" by gaoling, often for several months, women suspected of infecting soldiers.[9] Troops arriving in London on furlough were given lectures that stressed absolute continence as the only safe course, had pointed out to them what infection "means to the womanhood and the future citizenship of Canada as well as to their own usefulness as citizens," and, more practically, were "told as to what should be done to prevent infection."[10] Men who exposed themselves could report to the early treatment centres--called Blue Light Depots after the color of the bulb always kept burning over the door as a subtle advertisement of the purpose of the establishment--for a prophylactic cleansing with chemicals that supposedly prevented the infection from taking hold.[11] For those unfortunate enough to contract either syphilis or gonorrhea, punishment was meted out in the form of forfeited pay and lost leave.[12] Finally, no soldiers with open syphilitic lesions or with symptoms of acute gonorrhea were allowed to return to Canada without first being treated at one of the special VD hospitals.[13] Nevertheless, some were bound to bring VD home with them and with syphilis and gonorrhea already present among the civilian population, action was called for. Newton W. Rowell, President of the Privy Council, moving the second reading on 4 April 1919 of a bill to establish a health department, dared call the affliction by its name:

> A disease which in the past has been mentioned with bated breath, but which people now frankly recognize must be discussed and the situation faced, is venereal disease. I mention it because its existence is one of the urgent reasons for the creation of a Federal Department of Health. . . .[14]

Tuberculosis had been of concern to reformers since the turn of the century and starting in 1905, the federal government had given out an annual grant of $2000 to the Canadian Association for the Prevention of Tuberculosis.[15] The war again drew attention to the extent of the cost--in terms of death and ruined lives--of this disease to Canada. Some of the rejected recruits had been turned away because of tuberculosis. Even so, by September 1916, 397 tuberculous soldiers were being treated in various sanatoria throughout the country. Over half of these had never seen service outside Canada. Thirty more cases per month were expected to be invalided home from overseas.[16] In total, the Canadian army suffered 3123 cases of tuberculosis of the lungs during the war with 176 deaths. TB ranked fourth in number of infections among the troops after influenza, mumps and pneumonia.[17] Many more soldiers were discharged as healthy, only to have manifestations of the disease appear in later years.[18] Neither was the civilian population free from the white plague. In 1915, 8.5 percent of the total number of deaths in Canada had been due to tuberculosis.[19] During the four years of the war between forty and fifty thousand Canadian civilians succumbed to TB, a number approximating that of Canadian soldiers killed in the same period.[20] While it was expected that treatment of this disease would remain under the jurisdiction of the provinces, a federal health department was considered necessary

> to encourage uniform regulations in the various provinces; to assist in the important work of popular education; to disseminate technical information with regard to the care of the disease; and, generally, to stimulate interest in the struggle for its suppression.[21]

Canada had lost approximately one hundred thousand people from one disease and hostilities alone between 1914 and 1918. Tuberculosis is a disease of the young adult, peculiarly affecting those in the reproductive age group.[22] In addition, those soldiers lost in the war had also been of the age of reproduction and, by definition of having passed a physical exam, were the most healthy, the "best."[23] Many recruits were accepted despite diagnosis of venereal disease,[24] more were suspected of having contracted either syphilis or gonorrhea during service. It was expected that infection would pass from the military to the civilian population. The effects of these diseases on the reproductive capacity of both sexes were well known.[25] The influenza epidemic at the end of the war probably took an additional 50,000 Canadian lives, again mostly people in the prime of life.[26] The chances of Canada rebuilding its population through natural increase had therefore been impaired.

A related problem had been of concern to reformers since the late nineteenth century.[27] Canada had a shamefully high infant mortality rate. At the same time that Great Britain recorded a rate of 91 deaths of children less than one year of age for every one thousand live births and Australia and New Zealand boasted rates of 67 and 50 respectively, Canada had to admit to such figures as 105 in Manitoba, 107 in Ontario, a shocking 127 in Nova Scotia and a breath-taking 147 in Quebec. Even comparison with other North American urban centres did not let Canada off the hook. New York City's rate was 98.2 in 1915; Montreal only one year later almost doubled that figure, at 186.[28] One member of parliament speaking in the House of Commons was under the impression that the situation could be "very easily handled by making the Criminal Code a little more drastic in the passages that refer to murder,"[29] presumably referring to infanticide and perhaps, mistakenly, to abortion. Rowell replied that he doubted that "what my hon. friend refers to would be any more numerous in Canada than in the other countries."[30] The problem was instead due to living conditions in general and sanitation in particular.[31] Rowell felt funding and organization were more in order than criminal proceedings.

> We are willing to spend money to bring immigrants to Canada, yet there are dying in some of the great cities of our country, during the first year of their lives, twenty-five per cent of the babies born. I mention these facts to point out the urgent reasons why we in Canada should give serious consideration to this most important matter.[32]

Perhaps his choice of a higher estimate than normally given should be taken as an indication of his commitment to the establishment of a federal health department to deal with this sorry situation.

Immigration was the other solution to the problem of building population, but even at the best of times it was seen as a sad alternative. Charles Sheard summed up the general points held to by a common school of thought when he spoke in the House of Commons in favor of a federal health department.

> We have had in the past, rushing into this country, without restraint, inspection or restriction, the diseased, the mentally defective, the criminal, the unhappy, the uncertain, the infamous.[33]

A problem in the past, flooding of the country by defective immigrants was expected to become overwhelming in the post-war period.[34] Despite the perceived need for increased population, "[the] influx of immigrants . . . cannot be of advantage to the country if the principle is not firmly established that immigration must never be allowed to lower the national standard of public health."[35] The fear of immigrants particularly centred on the fear of feeblemindedness. Dr. Michael Steele, who for years carried the standard in the House of Commons for the establishment of a health department, professed before that body in 1917 that the chief reason for inception of a federal public health system was the prevention of the immigration of feebleminded into Canada after the war.[36] In an address before the Annual Congress of the Canadian Public Health Association [hereinafter CPHA] in Toronto in May 1919 he graphically explained why mental defectives posed such a threat. He claimed Canada had let into the country prior to the war, 1200 to 1500 "feebleminded people who in future years will by themselves and their prolific progeny burden and curse this country, producing in their various ramifications a social virus that cannot be exterminated from our land for centuries."[37]

One vague estimate gave the proportion of feebleminded in Canada as 0.5 to 1.5 percent of the population and added an estimated 14,000 insane for good measure. They were considered at best economic liabilities to the community and at worst spreaders not only of their own diseased mentality but of venereal disease, illegitimacy and immorality. "It is estimated that feeblemindedness is the source of 75% of our prostitutes."[38] "[Illegitimacy] and venereal diseases are directly in proportion to the number of mental defectives in any country . . .; our rescue homes are filled with mental defectives."[39] The projected new department was expected to deal with these problems, the related one of infant mortality and to help out with tuberculosis.[40] It also was taken for granted that in doing so, the department would join battle against another post-war threat, Bolshevism.

There existed an old idea among reformers--an idea that would hold on until the Depression of the 1930s--that sickness is the main cause of poverty. Edwin Chadwick, secretary of the Royal Commission to investigate Britain's poor laws said so in the 1830s.[41] Beatrice and

Sidney Webb published it in 1911.[42] A prominent United States social reformer quoted them in 1913[43] and Steele brought it up in the Canadian House of Commons in 1919, once again graphically describing the process by which this leads to social ruin:

> . . . sickness brings unemployment, which we are all striving to prevent. Unemployment is followed by poverty, poverty is followed by destitution, and destitution is followed by either charity or crime.[44]

Furthermore, not only were sick people a negative influence on Canadian society, eventually requiring either support or incarceration, they were a positive threat. It was difficult to convince the sick and their dependents of the merits of the democracy they had fought for.[45]

The most cogent explanation of how sickness threatened Canadian society and how health reforms would remove this threat came not from the federal arena but from British Columbia where a much more radical reform, state health insurance, was put forward. The B.C. Commission on Mothers' Pensions, Maternity Insurance and Public Health Nursing was appointed under the Public Inquiries Act in November 1919. Its report, submitted 18 March 1921, reinforced the old arguments that would indeed live on for at least another decade.[46]

> It is definitely known that sickness causes the great bulk of destitution. With the removal of sickness, a great part of the present-day distress would be withdrawn. . . . The bolsheviks of today are mainly the neglected children of yesterday. The big majority of them sprang from the homes of the poor, the handicapped, the sick and the scantily educated. . . .
> The child who is not given his chance today, who is neglected by society and so feels forced to fight society, will become a menace to that society that your child will have to reckon with. It is not enough that your child be healthy, well nurtured and trained; the other fellow's child must have his chance, must be healthy, properly developed and trained, or your boy when he reaches maturity and seeks to take his father's place in the world's work will find that the other fellow's boy has also reached the state of manhood a radical, who refuses to allow your son to work. If you will not assume responsibility for the

> health of the other fellow and his children, then you must do so for the sake of yourself and your . . . own . . .[47]

In other words, social legislation could be used to forestall revolution.

This was not an entirely fresh idea. Otto von Bismarck made no secret of his intent when he devised a comprehensive scheme of social insurance for Germany in the 1880s. Combined accident, sickness and old age insurance were meant to convince the working class that the state was "a social institution existing for their sake and interested in their welfare."[48] Coupled with the scheme was direct repressive legislation against Socialists. German paternalism became the model for social legislation in many western nations.[49] Its advantages to those interested in maintaining as much of the *status quo* as politically possible were pointed out by W. L. Mackenzie King in *Industry and Humanity*:

> Social insurance, which in reality is health insurance in one form or another, is a means employed in most industrial nations to bring about a wider measure of social justice, without, on the one hand, disturbing the institution of private property and its advantages to the Community, or, on the other hand, imperilling the thrift and industry of individuals.[50]

He also cited a more positive reward to industry for greater humanity in the form of caring for the health of workers--"the maintenance of standards of health is the surest means of maintaining standards of efficiency."[51] Promises of increased productivity by healthier workers were also made by the B.C. Commissioners.[52] The CPHA cited the health of Canadians as the country's "most priceless asset"[53] and Rowell saw the proposals he introduced "as part of the conservation of our human resources."[54] In short, public health reforms would yield a good return on investment.

Labor organizations themselves backed health reform. Although the Trades and Labor Congress came out in favor of a Department of Public Welfare rather than one of Health, the items it felt needed urgent attention fell within the range of tasks many reformers assigned to the field of public health--sanitation, town planning, housing plans and accident prevention.[55] The federal government had already started investigations into housing and town planning by early 1918.[56] Just how much labor and industry were in agreement on this aspect of reform is demonstrated by the fact that, in drawing up its submission to the federal government, the TLC collaborated, for the first time ever, with the Canadian Manufacturers Association.[57] They were joined by various and sundry other bodies, all calling for a health department. The Canadian Medical Association [hereinafter CMA] had been pressing for the establishment of a department since at least 1903.[58] The Women's Conference meeting in Ottawa in March 1918 at the request of the War Cabinet called for a Department of Public Health.[59] The National Council of Women laid virtually the same request before the federal-provincial conference in November 1918.[60] The Women's Section of the Saskatchewan Grain Growers added its voice.[61] The United Farm Women of Alberta declared public health a duty of government.[62] Major newspapers called for health reform.[63] Military authorities, specifically the Canadian Army Medical Service, wanted a health department, as did leading public health officials.[64]

In addition to taking on these new responsibilities, a federal department was expected to go on attempting to deal with the "sordidly material problems"[65] that had gradually accumulated over the years. When the British North America Act was passed, it carried precisely two references to health matters. One appears in section 91, Powers of Parliament. It assigns to the federal sphere responsibility for "Quarantine and the Establishment and Maintenance of Marine Hospitals." The second falls under Exclusive Powers of Provincial Legislatures and assigns to them "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Provinces, other than Marine Hospitals." The term "public health" was not yet in vogue in 1867.[66] Health care was considered a family, or at most, a community responsibility.[67] In 1896, the BNA Act was interpreted in a manner that placed the great majority of new functions under the jurisdiction of the provinces.[68] Among these previously unmentioned duties were all manner of public health measures. Not everyone was happy with this interpretation. A document from which Rowell cited frequently during his proposal of the health department bill stated that although it was natural that the provinces should look after public health administration as long as they could provide adequate service, the obligation rested finally with the federal government.

> Constitutionally, such matters as are not specified in the B.N.A. Act fall within the jurisdiction of the Dominion. Technically, therefore, public health, which in the modern sense is a new subject, falls within the cognizance of the Federal Government.[69]

It was now time for the Dominion to fulfill its obligations. As late as 1940, a book on the development of public health in Canada printed an article that insisted, after quoting sections 91 and 92 of the Act: "It is obvious that the Dominion has residual powers in regard to such activities of public health as are not definitely mentioned in the British North America Act."[70] The article, containing the same assertion, was reprinted, without editing, in a second version of the book published in 1962.[71] At the end of the Great War, the federal minister introducing the health department bill was, himself, not clear as to who had authority over what health matters. When pressed as to whether such a department would infringe on provincial rights under the BNA Act, Rowell cleared up the matter by stating: "I think the provinces clearly have jurisdiction, but the Federal Government also has jurisdiction. It seems to be a case of both having jurisdiction."[72]

With no master plan in effect, various items had been added, as they arose, to provincial and federal agencies alike. All the provinces had some sort of health board and by 1917 New Brunswick could boast the first ministry of health in the British Empire.[73] Under each of these boards there was a plethora of local and municipal health boards that had only recently, and only in some areas, begun to grow into more than stop-gap emergency organizations originally established to deal with the epidemic diseases of the eighteenth and nineteenth centuries, such as typhus and cholera.[74] Most provincial boards concentrated on the fields of quarantine, laboratory service and sanitary inspection. Some branched out into child welfare (Ontario) and publicity (Quebec, Ontario, Alberta and British Columbia). Nova Scotia, Quebec, Manitoba and Saskatchewan collected vital statistics. No province, with the possible exception of Saskatchewan, seemed to have a conscious plan in mind. The annual report of the ground-breaking New Brunswick health ministry did not even include anything on areas outside St. John and Fredericton. Prince Edward Island issued no annual health report at all.[75] The practice of all provinces was simply to address themselves to new problems as their solution became urgent.

Federal experience in dealing with health problems during the period between Confederation and the end of the Great War paralleled that of the provinces. Aside from the National Council of Health, which operated under the Commission of Conservation for the purpose of investigating matters of public health and giving advice thereon to the Dominion and the provinces, there were fifteen Departments handling some aspect of public health. Each Department had simply dealt, as they arose, with whatever health problems seemed relevant to matters already under its control. Agriculture checked the health of animals, inspected animals and carcasses at abattoirs engaged in international and interprovincial trade, maintained a laboratory for the testing and supply of sera and maintained inspectors to investigate outbreaks of disease. Customs checked dutiable foods and drinks for quality. Finance had jurisdiction over the transmission of infectious diseases through the handling of money just as the Post Office had over those transmitted by the handling of mail. The Post Office also guaranteed sanitation in its various stations. Immigration shouldered the heaviest load, inspecting immigrants for mental and physical health upon and subsequent to arrival and running detention hospitals for suspect cases. The Director-General of Public Health, an official of this Department, headed quarantine arrangements at ports and frontiers, administered the Public Works Health Act, supervised public health in the Yukon Territory, inspected vessels in ocean ports and ran Canada's leper lazarettos. Inland Revenue tested foods and beverages for adulteration. Interior looked after any medical and sanitary services that Indian Affairs might extend. Justice handled sanitation of prisons and the diseases of criminals. Marine maintained the marine hospitals that took in sick seamen. Supervision of the army medical corps, the military hospital services, sanitation in army camps and food supplies for the army was shared by the Departments of Militia and of Overseas Military Forces. Similarly, sanitation on ships and provision of food to the Navy came under the aegis of the Department of Naval Service which also looked into the diseases of fish and supervised health in fish hatcheries. Soldiers' Civil Re-establishment provided for the physical and mental restoration of soldiers affected by the war. Public Works provided sanitary inspectors for public buildings and the Census and Statistics Branch of Trade and Commerce compiled vital statistics.[76] As a federal health officer writing in the late 1930s succinctly summed up the federal system of public health provisions prevailing at the end of the Great War: "The whole thing lacked co-ordination."[77]

Actually the system had just recently been revamped to provide greater efficiency. As late as 1916, immigrants were inspected by the Interior, quarantined under Agriculture and, if sent to hospital, placed under Marines and Fisheries.[78] However, the revamping had not been very effective. The 1918-19 influenza epidemic easily broke down all health systems,[79] and the federal one was no exception. Rowell cited one example of the inability of the federal government to cope with the Spanish Flu. Saskatchewan had to go to the United States for literature to distribute on the flu because there was none available from the Canadian government.[80] He could have given numerous other examples. The Royal North West Mounted Police had trouble getting serum for northern Indians under their jurisdiction.[81] Medical officers in Whitehorse, Yukon could not stop possibly infected Americans from coming in from Skagway, Alaska.[82] And at least one senior federal quarantine official did not even know which Department he worked for.[83] It was on the local bodies that responsibility for caring for those suffering from the flu fell. Although a federal department could not have taken charge on a national scale, it could have issued authoritative warnings regarding the approach of the epidemic, distributed instructions to authorities regarding the proper measures to adopt, provided information to the populace regarding the best means of prevention and effective treatment, researched a preventive serum and collected statistics as to the true extent of the disease.[84] It was not considered too late for a new department to deal with the flu. It was one of the matters of concern discussed at the first meeting of the Dominion Council of Health [hereinafter DCH], in October 1919.[85] The next year, the *Canadian Medical Association Journal* made reference to "the present epidemic."[86] In fact, the failure to deal adequately with the 1918-19 post-war epidemic weighed so heavily on the consciences of Canadian health officials that the federal health department went to great pains to be ready for the repeat performance it expected to follow on the heels of World War II.[87]

The legislation that was supposed to coordinate all the old activities and initiate new ones was passed in the Canadian House of Commons on 11 April 1919. "[For] the preservation of health and the promotion of social welfare of the people of Canada," the new Canadian Department of Health was to "extend to and include all matters and questions relating to the promotion or preservation of the health of the people of Canada over which the Parliament of Canada has jurisdiction. . . ." It was also to co-operate with the provincial, territorial and other health authorities, in particular in the fields of conservation of child life and promotion of child welfare; to provide a national laboratory; to inspect and care for immigrants and seamen and to administer the marine hospitals; to conserve the health of civil servants by supervising federal public buildings and offices; to fulfill the treaty with the United States relating to the pollution of boundary waters; to administer the Quarantine, Adulteration, Public Works Health, Leprosy, Proprietary or Patent Medicine Acts and parts of the Canada Shipping Act; to collect, publish and distribute relevant information; and to deal with such other matters as might be referred to the Department by the Governor in Council. It also provided for the establishment of the Dominion Council of Health which was to act as a liaison between provincial and federal health officials and between these officials and lay organizations interested in health.[88]

The bill was given assent on 6 June 1919. Only a year later the new department would be under attack in the House of Commons, charged with lack of form.[89] It showed all the trappings of the old stop-gap approach to health planning in Canada. There had been no real attempt to rationalize the old activities of the various departments, just to house them all under one roof. Neither had anything really concrete been done regarding the new reforms that had been called for. It was up to the Dominion Council of Health and to the officials of the Department itself to bring order out of chaos. They would fail--not so much because the problems addressed were insoluble but because they could not be remedied by application of the means the Department had to hand.

NOTES

[1] Newton W. Rowell, Canada, House of Commons, *Debates* [hereinafter Commons, *Debates*], 1919, p. 1165.

[2] Canada, Senate, *Debates* [hereinafter Senate, *Debates*], 1919, p. 287.

[3] Public Archives of Canada [hereinafter PAC], Records of the National Council of Women of Canada, MG 28 I 25, vol. 67. Jennie E. Smillie, *Special Report on Control of Venereal Diseases* (Ottawa: The National Council of Women, 1917), p. 4.

[4] Andrew Macphail, *Official History of the Canadian Forces in the Great War, 1914-19: The Medical Services* (Ottawa: F. A. Acland, 1925), p. 293.

[5] J. J. Heagerty, "Venereal Disease Control during Wartime," *Canadian Public Health Journal* [hereinafter *CPHJ*], XXX (December 1939), 567.

[6] Provincial Archives of Alberta [hereinafter PAA], Premiers' Papers, File #0433. "Venereal Disease Statistics" [1924?].

[7] PAC, Rowell Papers, MG 27 II D13, vol. 18. Memorandum for the Honourable the Minister, 18 July 1918.

[8] *Ibid.*

[9] *Ibid.*, Major-General G. L. Foster, Surgeon-General, Director of Medical Services, Canadian Contingents, Memorandum of Meeting re V.D., 27 February 1918. During May 1918, ten women were dealt with under the Defence of the Realm Regulation in the Witley area where Canadian troops were stationed. Their average imprisonment was four and a half months. *Ibid.*, Venereal Disease occurring among the Canadian troops, Witley Area, May 1918.

[10] *Ibid.*, Seymour Bullock of the Canadian Viseeing Office, London to N. W. Rowell, 15 July 1918.

[11] *Ibid.*, Brigadier-General P. E. Thacker, Adjutant-General, Canadian to the Secretary, The War Office, Whitehall, 27 March 1918.

[12] *Ibid.*, Bullock to Rowell, 15 July 1918.

[13] *Ibid.*, Foster, The Venereal Situation, 12 June 1918.

[14] Commons, *Debates*, 1919, p. 1166.

[15] G. J. Wherrett, *The Miracle of the Empty Beds: A History of Tuberculosis in Canada* (Toronto and Buffalo: University of Toronto Press, 1977), pp. 18-22.

[16] "The Tuberculous Soldier," Editorial, *Canadian Medical Association Journal* [hereinafter *CMAJ*], VI (1916), 922-3, quoted in full in *ibid.*, pp. 122-3.

[17] Macphail, p. 273.

[18] The Central Alberta Sanatorium (now called the Baker Memorial Sanatorium) outside Calgary, Alberta was established in 1920 partly to take care of tuberculous soldiers and ex-soldiers. Its files contain several examples of men who left the army sure of their health but who entered and sometimes re-entered the San in later years. One extreme example was under treatment during eight separate stays between 1923 and 1954. Baker Memorial Sanatorium [hereinafter BMS], Patient file #1038.

[19] PAC, Records of the Department of National Health and Welfare, RG 29, vol. 19 (file 10-3-1, part 2). Report to the Vice-Chairman of the War Committee of the Cabinet on the Establishment of a Federal Department of Public Health, 25 October 1918, p. 15.

[20] The Canadian Association for the Prevention of Tuberculosis, *The Nineteenth Annual Report*, 1919, p. 14.

[21] PAC, RG 29, vol. 19 (file 10-3-1, part 2). Report to the vice-chairman of the war committee . . ., pp. 15-16.

[22] During 1924, 76 percent of those who died in or were discharged from the Central Alberta Sanatorium were between the ages of sixteen and forty. Alberta, *Annual Report of the Department of Public Health, 1924* (Edmonton: King's Printer, 1926), p. 44. According to the medical thinking of the time, young men discharged were restricted in the strenuousness of employment they could take and the activity of entertainment they could pursue. This might interfere with the chance to marry and also to produce legitimate children. In a reply to a young man who had been released with tuberculosis in an arrested state and who wrote to ask if he should go ahead with his proposed marriage to the fiancee who had stood by him during his treatment, Dr. A. H. Baker, the Medical Superintendent of the Central Alberta Sanatorium warned: "It would be unfortunate for you to get married and then find that you had to break away to a great extent from your quiet life both in order to please your wife from a social standpoint and also to increase your income through greater effort." He advises, however, that if the woman really loves him, a good marriage can be worked out despite the necessary limitations but that risks of a second breakdown must be avoided. 29 March 1921. BMS, File #2, General Correspondence, Oct. 20, 1920 to Dec. 31, 1920; Jan. 1, 1921 to Dec. 31, 1921. Women who had undergone treatment were not under the same pressure to work after discharge. However, even a young woman totally supported by her husband and helped out by a domestic servant in the home was considered to be in great peril if she conceived. A woman who was admitted at the age of 22 in 1926 to the Central Alberta Sanatorium and who had a six month old son at the time of admission later underwent two abortions by "very understanding Doctors" because: "Upon leaving the San my husband was advised that

under no circumstances were we to have any more family. . . ." Letter to medical superintendent, 13 December 1951, BMS, patient file #1037. She wrote, at age 48, to say she feared she was pregnant again, that the doctors who had helped her out previously were both dead and she needed advice as to whether she should go to a TB clinic, "[or] could you put me in touch with a doctor who would understand my case."

[23] Rowell, Commons, *Debates*, 1919, p. 1164.

[24] *Ibid.*, p. 1167, Rowell.

[25] PAC, MG 27 II D13, vol. 18. Bullock sent Rowell excerpts from Georges Thibierge, *Syphilis and the Army*, ed. by C. F. Marshall (London: University of London Press, 1918) which warned that infected men fathered dead or deformed children and passed the same debility on to their wives. For literature for public consumption see PAC, MG 28 I 25, vol. 67. "The Venereal Diseases," issued by the Department of the Public Health, Nova Scotia, May 1917.

[26] J. P. Dickin McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919," Canadian Historical Association, *Historical Papers* (1977), p. 125.

[27] Suzann Buckley, "Efforts to reduce infant maternity mortality in Canada between the two World Wars, *Atlantis*, II (Spring 1977), 76. See also Suzann Buckley, "Ladies or Midwives? Efforts to reduce infant and maternal mortality," in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada, 1880s - 1920s* (Toronto: The Women's Press, 1979).

[28] PAC, RG 29, vol. 19 (file 10-3-1, part 2), Report to the vice-chairman of the war committee . . ., p. 18.

[29] Robert H. Butts, Commons, *Debates*, 1919, p. 1171.

[30] *Ibid.*

[31] See the chapter on public health in Terry Copp, *The Anatomy on Poverty. The Condition of the Working Class in Montreal 1897-1929* (Toronto: McClelland and Stewart, 1974), pp. 88-105.

[32] Commons, *Debates*, 1919, p. 1166.

[33] *Ibid.*, p. 82. For another adherent to this theory see Charles B. Sutherland, "Replacing the Cannon Fodder," *CPHJ*, VI (April 1915), 168-72.

[34] Peter McGibbon, Commons, *Debates*, 1919, p. 184.

[35] PAC, RG 29, vol. 19 (file 10-3-1, part 2), Report to the vice-chairman of the war committee . . ., p. 19.

[36] Commons, *Debates*, 1917, pp. 992-7.

[37] Dr. Michael Steele, M.P., "The Federal Department of Health," *CPHJ*, X (June 1919), 264.

[38] PAC, RG 29, vol. 19 (file 10-3-1, part 2), Report to the vice-chairman of the war committee . . . ., p. 17.

[39] Dr. Robert J. Manion, Commons, *Debates*, 1919, p. 1181.

[40] "A Federal Department of Health," editorial, *CPHJ*, IX (July 1918), 345.

[41] Jack A. Blyth, *The Canadian Social Inheritance* (Toronto: Copp Clark, 1972), p. 92.

[42] "We are apt to forget that in all countries, at all ages, it is sickness to which the greatest bulk of destitution is immediately due." Sidney and Beatrice Webb, *The Prevention of Destitution* (London: by the authors, 1916), p. 15. First edition in 1911.

[43] I. M. Rubinow, *Social Insurance* (New York: Arno and the New York Times, 1969), p. 205. Reprint of 1913 edition.

[44] Commons, *Debates*, 1919, p. 98.

[45] *Ibid.*, p. 99.

[46] Margaret Kirkpatrick Strong is still resurrecting the old sickness-causes-poverty link in *Public Welfare Administration in Canada*, Social Service monographs, no. 10 (Chicago: University of Chicago Press, 1930), pp. 114-5.

[47] Quoted in D. L. Matters, "A Report on Health Insurance: 1919," *B.C. Studies*, XXI (Spring 1974), 31-2. It will be noted that the commissioners did not see insurance of health as the entire solution. Education was also necessary but they explained that unhealthy children are unable to assimilate what is taught them.

[48] W. H. Dawson, *Social Insurance in Germany, 1883-1911*, quoted in James Sedley Cudmore, "A Comparative study of health insurance and public medical care schemes in Germany, Great Britain, and the United States of America, and Canada" (unpublished Ph.D. dissertation, University of Toronto, 1951), p. 7.

[49] The association of this type of legislation with Germany was so strong that it actually held back social insurance measures proposed in the United States at about the same time as in Canada. They were labelled "pro-German" and "made in Germany." Clarke A. Chambers, *Seedtime for Reform: American Social Service and Social Action, 1918-1933* (Minneapolis: University of Minnesota Press, 1963), pp. 156-8.

[50] William L. Mackenzie King, *Industry and Humanity. A Study in the principles underlying industrial reconstruction* (Toronto: University of Toronto Press, 1973), p. 222. Originally published in 1918.

[51] *Ibid.*, p. 232.

[52] Matters, p. 29.

[53] "The Federal Department of Health," editorial, *CPHJ*, X (March 1919), 141.

[54] Commons, *Debates*, 1918, p. 2289.

[55] Rowell, *Ibid.*, 1919, p. 1169.

[56] Rowell, *Ibid.*, 1918, p. 2289.

[57] Rowell, *Ibid.*, 1919, p. 1169.

[58] PAC, RG 29, vol. 19 (file 10-3-1, part 1) Canadian Medical Association, *Public Health Department for the Dominion of Canada* (Toronto: Canadian Medical Association, n.d.). This is a thirteen-page booklet compiled by George Elliott, M.D., General Secretary of the CMA, containing the various memoranda submitted between 1903 and 1908 on this topic by the CMA to the federal Director-General of Health.

[59] Rowell, Commons, *Debates*, 1919, p. 1168.

[60] Canada, Federal-Provincial Conference, Conference 7, Ottawa, November 1918, pp. 98-9.

[61] Rowell, Commons, *Debates*, 1919, p. 1168.

[62] Paul V. Collins, "The Public Health policies of the United Farmers of Alberta government, 1921-1935" (unpublished M.A. thesis, University of Western Ontario, 1969), p. 10.

[63] Quoted in PAC, RG 29, vol. 19 (file 10-3-1, part 2), Report to the vice-chairman of the war committee . . ., pp. 3-5.

[64] Rowell, Commons, *Debates*, 1919, pp. 1168-9.

[65] "A Federal Department of Health" (1918), 345.

[66] R. D. Defries, ed., *The Development of Public Health in Canada* (Toronto: Canadian Public Health Association, 1940), p. vii.

[67] Peter Aucoin, "Federal Health Care Policy," in *Issues in Canadian Public Policy*, ed. by G. Bruce Doern and V. Seymour Wilson (Toronto: Macmillan, 1974), p. 55.

[68] Anthony H. Birch, *Federalism, Finance and Social Legislation in Canada, Australia and the United States* (Toronto: Oxford University Press, 1955), p. 73.

[69] PAC, RG 29, vol. 19 (file 10-3-1, part 2), Report to the vice-chairman of the war committee . . ., p. 28.

[70] K. F. Brandon, "Public Health in Upper Canada," in Defries, *The Development of Public Health in Canada*, p. 65.

[71] K. F. Brandon, "Public Health in Upper Canada," in *The Federal and Provincial Health Services in Canada*, 2nd edition, ed. by R. D. Defries (Toronto: Canadian Public Health Association, 1962), p. 139.

[72] Commons, *Debates*, 1919, p. 1170.

[73] The other provinces followed in raising health to the ministerial level: Alberta (1919), Ontario and Saskatchewan (1923), Manitoba and Prince Edward Island (1928), Nova Scotia (1931), Quebec (1936), and British Columbia (1946).

[74] See Defries, ed., *The Development of Public Health in Canada*, p. vii, and *The Federal and Provincial Health Services in Canada*, pp. 136-7.

[75] See the section on "Administration of Public Health under Provincial Governments," in PAC, RG 29, vol. 19 (file 10-3-1, part 2), Report to the vice-chairman of the war committee . . ., pp. 24-25c.

[76] *Ibid.*, pp. 21-2.

[77] J. J. Heagerty, "Public Health in Canada," in Defries, *The Development of Public Health in Canada*, p. 8.

[78] Steele, Commons, *Debates*, 1916, pp. 1166-7.

[79] The breakdown of Canadian health systems at the federal, provincial and municipal levels in the face of the flu is covered in detail in Dickin McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919."

[80] Commons, *Debates*, 1919, p. 1174.

[81] PAC, RCMP Records, RG 18, vol. 567.

[82] PAC, Yukon Territories Records, RG 91, vol. 67 and RG 18, vol. 567.

[83] PAC, RG 29, vol. 300. Telegram from Dr. G. E. Martineau, Inspecting Physician at Grosse Isle to W. W. Corry, Acting Deputy Minister of Immigration and Colonization, 9 July 1918.

[84] PAC, RG 29, vol. 19 (file 10-3-1, part 1), Report to the vice-chairman of the war committee . . ., pp. 14-5.

[85] PAC, Records of the Dominion Council of Health [hereinafter DCH Minutes], 1st meeting, 7-9 October 1919, pp. 3-4.

[86] Editorial, *CMAJ*, X (April 1920), 372.

[87] PAC, RG 29, vol. 858 (file 20-C-33, part 1). Correspondence between the Department and the Canadian Medical Association, May-December 1943.

[88] For a full text of "An Act Respecting the Department of Health (1919)," see Appendix A.

[89] "My critique of the whole of this item is that it looks very much as if the minister were struggling to find something for this new department to do. I never saw such a mixture before--adulteration of food, proprietary or patent medicines, housing, bees, pollution of boundary waters, marine hospitals, quarantine, immigration and medical inspection, research and venereal diseases . . . It strikes me that the mixture which is to be found in this item is pretty good proof that there was no necessity for building up this big administration, and these things are gathered together as an excuse for spending a great deal of money in a new department." John H. Sinclair, 14 June 1920. Commons, *Debates*, 1920, p. 3541.

> [It] was foreseen that the activities of the department would increase from year to year, but on account of financial conditions it has been the endeavour of my predecessor and myself to restrict as much as possible the expansion of the Department of Health. It is more or less a co-ordinating department, co-ordinating the activities which were previously carried on by the Department of Agriculture, the Department of Immigration and some other departments.
> --Henri S. Béland, Minister of Health, in the House of Commons, 27 May 1925.

Chapter Two

THE PREVENTION OF DISEASE

ADEQUATE CARE-TAKING, 1919-29

Throughout the nineteenth century, in Canada and elsewhere, boards of health were established in direct consequence of epidemics. Such boards labored to keep threatening diseases out of their jurisdiction and, once they inevitably entered, to confine them to as few communities or individuals as possible. Simple quarantine was the cornerstone of public health. By the time Canada's Department of Health was established, the concept of public health had progressed beyond this rudimentary type of disease prevention. Certainly Canadian reformers stressed the obverse aspect of promotion of health. The new federal Department of Health had set out for it tasks of the latter, as well as of the former, nature. Unfortunately, limits of jurisdiction over health in Canada were vague. This caused numerous complications when dealing with the other Canadian governments. For example, according to the BNA Act, the federal government was in charge of prevention of the spread of disease. In the case of tuberculosis, the accepted mode of prevention at the time involved segregation of the tuberculous into sanatoria. However, the provinces were in charge of institutional care. This included tuberculosis sanatoria. Prevention and cure were clearly too connected here to make separation of jurisdiction a simple matter. The most important other group with which the federal government had to share command was the medical profession. Government was not to meddle in doctors' business--that of curing. This involved a rather delicate balance. In the case of the venereal diseases, the only feasible way to prevent spread was to cure the infected. In attempting to prevent the spread of VD in Canada, the department had to make forays both into the provincial reserve of care and into the professional reserve of cure. The Department of Health was constantly faced with other subtleties of like nature. Although it tried to unravel the lines and to make a positive contribution to the public health, it never managed, throughout nine years of solitary existence, to rid itself of the quarantine syndrome. The Department concentrated on keeping disease and, to some extent, disease-making things away from "healthy" Canadians. In fields where this negative approach could not be applied, the Department failed to make any real progress in the promotion of health.

Anyone who cherished fond hopes that the new Department would spearhead a reorganization of provisions for health in Canada should have been warned by the debate over the bill for its establishment. Newton Rowell went out of his way to stress that the federal government would not be stepping on any provincial toes. He gave assurance that the Dominion would make

> no encroachment upon the jurisdiction of the provincial departments of health. No such idea is in view, nor is it contemplated by the Bill, which is supported and expressly requested by the authorities of the different provinces."[1]

He also spoke in glowing terms of the "marvellous result the medical profession has secured in the case of the soldiers in all of the armies at the front,"[2] an indication that the new Department was not meant to shake up anything in that connection either. In fact, although he outlined the areas in which the Department was to take new initiative, Rowell's concrete proposals were severely limited. He felt there was a place for prevention of the spread of disease, such as the Department of Agriculture handled for animals[3] and for better housing and sanitary conditions.[4] However, the only mechanism by which the Department might accomplish such things that he put forth was that of publicity.

> [Its] actions might very properly be limited to collecting information and furnishing it to all who may desire to take advantage of it, there is no question that there is a very important field of activity open in that respect.[5]

This faith in the power of education would soon be disappointed.

The first Canadian federal Department of Health was staffed during the summer of 1919 and was functioning by early summer. Staffing had not been accomplished without difficulties. It was felt by some members of the House of Commons that the really prominent scientific and medical men wanted to run the Department would be insulted by having their credentials assessed, as was usually the case with government appointments of this type, by the Civil Service Commission. As one alternative, a suggestion was made that a special commission of medical men be established to find men for the top positions.[6] As it was, the government had more eager candidates than it wanted. Feelings were running high. On 31 March 1919, Dr. Frederick Montizambert, Director General of Public Health under the Department of Immigration and Colonization wrote the following letter to the Honorable J. A. Calder, his minister.

> I see in Saturday's Citizen [sic] the statement that the name of Dr. H. P. [sic] Bryce is spoken of as the first Deputy Minister of Health.
>
> Whether this is officially inspired or is given to the press by Dr. Bryce himself, as evidence of his wishes, I have no means of being certain.
>
> I have not approached you on this subject because I have felt, and do feel, that my claims for that office so far transcend those of anyone else that it is inconceivable that the Government should pass me over.
>
> According to the Civil Service list, Dr. Bryce has had ten years of permanent service as Medical Inspector of Immigrants, while I have had over fifty years of permanent service, the last twenty of them as Director-General of Public Health and Sanitary Adviser of the Dominion Government, with rank of Deputy Minister.
>
> My long service and my attainments fully entitle me to recognition as the first Deputy Minister of Health.
>
> If after a brief tenure of the office by me, the Government desires to appoint someone else, my services can then be retained by making me consulting sanitary adviser of the Dominion Goverment, as was done for Mr. Schreiber as consulting engineer of the Railway Department and is now being done for Mr. Ewart as consulting chief architect of the Public Works Department.
>
> This, as in their cases, would be only a fitting recognition of long and faithful services, and my successor, if even superficial and impractical, will then have the advantage of my long experience and knowledge.[7]

Montizambert had certainly fought hard for the establishment of a health department since at least 1902.[8] However, at the time of writing he was 76 years old, having indeed been employed in the Canadian federal public health service since 1866. He had reason to be proud of his achievements and had been accorded several official honors. But he evidenced a lack of ability to act in co-operation with other people. When asked in January 1919 if he felt the establishment of a council to advise the head of the new health department was a good idea, he replied: "I may say without egotism that from my lifelong experience in the Public Health service of the country, I have not felt very urgently the necessity of such an advisory council." Still, he felt such an organization might be a good thing as he should have to retire "someday" and there was no one at present who could claim qualifications equal to his own. The council could then help out the "inexperienced man."[9] The Director-General also held some fascinating medical opinions including the notion that women were not meant to work outside the home because they had no moustaches to brush up to keep dust out of their noses and no beards to protect their throats and chests from flying objects.[10]

The man Montizambert felt was trying to usurp his rightful position as the first Canadian Deputy Minister of Health was Dr. Peter H. Bryce who had been appointed, in 1905, first General Medical Superintendent in charge of the health of Indians. He had worked hard to quell tuberculosis but in pressing to have all Indian schools given to him to administer as sanatoria he made himself so unpopular that he was dismissed in 1910 and the post left unfilled until 1927.[11] Bryce had served since then as the Chief Medical Officer of the Immigration Branch and he was offered the chance to continue in this role under the new Department.[12]

Montizambert was offered the post of Director of the Quarantine Branch in the new administration.[13] Instead, he resigned.[14] His successful rival for the chief administrative position was Lt.-Col. John Andrew Amyot, M.B., C.M.G., a man a quarter-century Montizambert's junior and a veteran of the Great War as well as of public health service in Canada. Born and educated in Toronto, he had held, among other posts, those of Director of the Provincial Board of Health Laboratory in Ontario from 1900 to 1918 at the same time as he was a professor at his alma mater, the University of Toronto. He was particularly remembered for his work as a member of the International Joint Commission which investigated the problem of pollution in the Great Lakes in 1912-13. As a result of this investigation he worked to introduce into Canada filtration and chlorination of water and the pasteurization of milk, measures specifically meant to combat typhoid fever but having beneficial effects in other areas of health as well. In 1915, Amyot proceeded to England as a member of the staff of No. 4 General Hospital, University of Toronto. While serving with the Canadian Expeditionary Force he was mentioned twice in dispatches and decorated by the British and French governments. His specialty during the war was sanitation and he had distinguished himself during the influenza epidemic.[15] In addition, he was French Canadian and Roman Catholic, points which Rowell brought up in the House when accused of being a bigot but which he insisted had nothing to do with the decision.[16] Appointed in March 1919, Amyot was back in Canada by the end of May to take up his new duties.[17]

Amyot's salary as Deputy Minister was six thousand dollars. J. D. Pagé, as Chief of the Quarantine, Immigration and Marine Hospitals Branch was paid five thousand dollars. The Assistant Deputy Minister, D. A. Clark, and the Chief Dominion Analyst, A. McGill, each received $4200. C. A. Hodgetts, Chief of the Sanitary Statistics, Library and Publications Branch came next at $4100 and Helen MacMurchy, as head of the Child Welfare Branch, followed him closely at four thousand dollars. The other two chief executives of the Department were J. J. Heagerty, getting $3540 as the Chief of the Venereal Disease Control Branch and F. H. Brown, the Secretary, at $2820.[18] Amyot had had some trouble holding on to both an Assistant Deputy Minister and a Secretary. The Treasury Branch felt that the "Department has been only a recent organization and if the extent of its work and its operations are of such a character as to require the payment for such services, the Board would be glad to have confirmation of such a fact."[19] The Deputy Minister won his case on the grounds that the Department had inherited considerable old work, had had assigned to it new work and expected more in the future.[20] Some staff members had been transferred along with their divisions from their former departments. Immigration and Colonization signed over thirty-two employees including not only Montizambert and Bryce, both of whom resigned before the transfer was complete, but also, among others, a laundress, a cabin boy and a waiter.[21] New staff was sought for heretofore non-existent duties. The proposed Sanitary Statistics, Library and Publications Branch drew up a list of needed personnel: a director of publicity, a medical French translator, a secretary stenographer, a clerk, another clerk in charge of publications, a multigraph and addressograph operator, a health statistician and a librarian.[22] Newton Wesley Rowell, the President of the Privy Council, was to double as Minister of Health.[23]

The appropriations for the first year were $685,500. Less than half a million of this was spent owing to the fact that several divisions were not yet functioning at full strength.[24] By 1921, appropriations had risen to just under one million dollars. This was to change little throughout the solitary existence of the Department.[25] Originally, ten divisions were established: the Quarantine, Immigration

Medical and Marine Hospitals Services, the Food and Drugs laboratory and the Proprietary or Patent Medicines section, all transferred from other Departments; and the newly-created Divisions of Opium and Narcotic Drugs, Venereal Disease Control, Publicity and Statistics, Child Welfare and Housing.[26] With one exception, the only divisions that would lead uninterrupted lives from the end of the Great War to the end of the Second World War were the first five--all of which had established their places in federal jurisdiction and fitted neatly into the concept of disease prevention through prevention of contact with disease. Of the more innovative divisions, Publicity would last a mere two years as a separate entity, although various sections of the Department worked hard throughout the period to disseminate information to interested parties. Still, publicity did not take an aggressive role again until 1939, when propaganda became part of the new war effort. Housing lasted a bare five years and never reappeared. Child Welfare and Venereal Disease Control, those answers to two of the most compelling requests put forth by ante- and post-bellum reformers, both foundered in the depths of the Depression--the former to arrive back on the government books during the new push for reform in the late 1930s, the latter to wait until 1944 when venereal disease had again shown itself as a complication of war. The only new division in 1919 that established itself on a steady basis was that of Opium and Narcotic Drugs. This was so because it fitted in from the beginning with the five transferred divisions. Rather than introduce measures to deal with drug addiction as a health problem, Narcotics was in charge of keeping illegal drugs out of the country and stamping out drug addiction within the country by repressive tactics. This closely paralleled Quarantine's approach to keeping out infectious diseases, the approach of the Immigration Medical Service to keeping out chronic disease, and that of Food and Drugs and Proprietary or Patent Medicines to warding off sick-making items of consumption.

During the first years, the Department added Divisions of Hospitalization and Public Health Engineering which took over administration of the Public Works Health Act and Canada's responsibilities regarding pollution of waters. A Laboratory of Hygiene was also established within the Food and Drugs section. However, from 1919 to 1928, the federal Department of Health consistently failed to fulfill its obligations in one of the two broad fields set out for it in the establishing Bill. Although it kept on working to prevent disease, it never succeeded in breaking into the field of health promotion. This should not be blamed on the officials of the Department. There is plentiful evidence in the minutes of the Dominion Council of Health, the agency set up to provide liaison between the provinces and the Dominion, that Amyot and others wanted to take progressive steps. But the Department was constrained by jurisdictional scuffles, lack of money and, not least of all, by political policy.[27] The picture of the only separate federal Department of Health ever to exist in Canada is one of adequate care-taking and stalemated reform. Between the time of its birth and of its marriage to another veteran of the Great War, the Department of Soldiers' Civil Re-establishment, it carried on its work as best it could, fighting retrenchment and managing to make modest, although not innovative, expansions.

What undoubtedly constituted the three most powerful divisions of the Department of Health were the Quarantine, the Marine Hospitals and the Immigration Medical Services. These three watchdogs of our borders received well over one third of the Department's appropriations.[28] The Quarantine Service alone took up more than one quarter of the Department's budget.[29] Probably the oldest health activity of the federal government, Quarantine was transferred from the Department of Immigration and Colonization on 1 September 1919.[30] Its basic duty was to administer Canada's eleven quarantine stations[31]--at Halifax, North Sydney and Louisbourg, Nova Scotia; at Chatham, Bathurst, Campbellton and Saint John, New Brunswick; at Charlottetown, P.E.I.; at Grosse Isle, Quebec; and at William Head and Prince Rupert, British Columbia. The function of these stations was to prevent the entry into Canada of all infectious diseases, major or minor. All passengers were inspected by a medical officer and detention barracks and hospitals were provided for those who did not pass.[32] The most important of the stations was Grosse Isle in the St. Lawrence River, established in 1832 in response to the cholera epidemics. At the time the Department took it over, it could house 1082 in its detention barracks and 130 in its hospital, with tents available if more beds were needed. The station was inefficient to operate--the hospital and detention divisions were widely separated because they were erected at a time when it was still thought that disease was transmitted by vapors in the air. Not only that, the whole idea of island quarantine was becoming recognized as obsolete. The Dominion Council of Health urged in October 1921 that Canada follow the lead of Great Britain and the United States by applying federal quarantine only to the major communicable diseases.[33] This advice had been followed by 1924, and sufferers from measles, scarlet fever, diphtheria and chicken pox were allowed to proceed for treatment to the Immigration Hospital in Quebec City.[34] The same year, other restrictions were relaxed to speed the flow of traffic in the river. Arrangements were made for the medical inspector to board with the pilot further downstream at Father Point. If no infectious diseases were found, there was no need for the ship to lay over at Grosse Isle. At night vessels were allowed past on the sworn statement of the ship's captain and medical officer.[35]

In 1926, Canada adopted the Articles of the International Sanitary Convention of Paris which reduced quarantinable diseases to plague, cholera, yellow fever, typhus and smallpox.[36] The Articles provided for fumigation of ships to eradicate plague and the Department experimented with various methods--including cyanide, "Zyklon B" and sulphur dioxide[37]--to kill rats.[38] The service also disinfected articles that might carry disease into the country[39] and in one case, made a foray into the field of public health by undertaking mass vaccination of Windsor inhabitants to prevent a serious epidemic of hemorrhagic smallpox centred in Detroit from gaining a foothold in Canada.[40] Otherwise, the service simply administered the quarantine stations,[41] right down to such details as a testy exchange over why the Department should pay to replace a five and a half dollar tennis net worn out beyond repair by "Japanese Saloon passengers, and by Officers of the Canadian Siberian Expeditionary Force."[42] By the end of the 1920s it was apparent that the cumbersome system of quarantine stations was no longer needed. In 1926, 2,737 vessels were inspected and 40,888 persons examined under the Quarantine Act. Only 84 persons were sent to quarantine hospitals or detention buildings.[43] Over half of these went to Grosse Isle where one case of smallpox and 45 contacts were easily accommodated in this facility of over 1200 beds. That had been a heavy year for Grosse Isle. Since 1920 the only other residents had been one case of smallpox and two contacts in 1922. Further detainees before the end of the decade amounted to another case of smallpox and seven contacts and one case of typhus fever accompanied by one contact, all in 1927.[44] Still the quarantine stations survived the Department of Health and had to wait for the economies of the Depression before the system was cut back to a size realistic for the twentieth century.

In much the same spirit as border quarantine, this service also provided for compulsory detention and medical treatment of all lepers discovered in Canada.[45] The first known case of leprosy in Canada was reported in New Brunswick in 1815.[46] This matter came under federal jurisdiction with the passing into law of "An Act Respecting Leprosy" in 1906. At that time, the Dominion took over a lazaretto in New Brunswick that originally had been established in 1884 on Shelldrake Island in the Miramichi River[47] to house twenty-seven lepers whose presence in the community was causing alarm. By 1868, the inmates were transferred to the nursing care of *Les Réligieuses de l'Hotel Dieu de St. Joseph de Tracadie*, none of whom even contracted the disease.[48] This leprosarium catered mostly to the native-born, foci of leprosy occurring not only in New Brunswick but also in nearby Nova Scotia and, later, in Saskatchewan.[49] By the end of the 1920s the institution at Tracadie, which usually housed about ten inmates in one large building, had cared for at least 150 lepers and it is possible that others may have lived their lives nearby without ever having been diagnosed. Although it was realized by this time that leprosy is one of the least contagious of infectious diseases, many cases stayed on long after the disease was arrested. They were so badly maimed that they could never hope to regain their places in the community.[50]

The same Act that took over the New Brunswick lazaretto in 1906 established another on the coast of British Columbia. The first known case had been reported there in 1882 and isolation accommodation provided since 1892.[51] The federal lazaretto was originally established at D'Arcy Island and used only as a deportation depot until 1917. After a law was passed that no one who had lived in Canada longer than five years could be deported, the establishment was moved to Bentinck Island, adjacent to the William Head Quarantine Station in 1923. Here about ten patients, usually all male, all Chinese and all foreign-born though residing of late on the B.C. coast, lived in cottages, each with his own room. Unlike the inmates of Tracadie, their needs were looked after by only two caretakers and one nurse. Unless unable by reason of advanced illness, the lepers tended their own quarters, cooked, cut wood, cultivated gardens and raised chickens. Although medical treatment here too allowed for some improvement or at least arrest of the disease, most inmates were there till death, which could come at quite an advanced age.[52] By the time the Department amalgamated with Pensions, British Columbia had not reported a native case of leprosy since 1919. Tracadie also was beginning to house an increasing proportion of foreign-born lepers by this point. The country sought to control leprosy through application of classic measures of quarantine. Carriers were either kept out of Canada in the first place or, once in, or if born there, they were kept away from other Canadians. This was prevention of the type long accepted as being in the federal sphere.

A service closely allied in administration and philosophy to quarantine was the Marine Hospitals Division. Establishment of such hospitals was the only specific health responsibility other than quarantine to be assigned to the Dominion under the BNA Act. Before 1867, communities simply had to provide as best they could for sick mariners left behind by foreign vessels.[53] Some sort of provision for these unfortunate sailors was not simply a matter of humanitarianism. In 1822, the Legislature of New Brunswick voted five hundred pounds for the establishment of a marine hospital and pest house, the city of Saint John providing the land.[54] Once safely ensconced in such an institution, a diseased mariner would not pass his infection to the general public. Under Part V of the Canada Shipping Act, relating to Sick and Distressed Mariners, medical, surgical and other treatment were to be provided as required to sick mariners employed on board any ship that had paid appropriate dues during the current calendar year.[55] Originally administered under the Department of Marine, the service was transferred to the new Department of Health in November 1919.[56] At that time, the dues were one and one half cents per registered ton for any vessel arriving in any port in the salt water provinces of Quebec, Nova Scotia, New Brunswick, Prince Edward Island and British Columbia from foreign ports or engaging in inter-provincial trade. Fishing and government vessels had the option of paying or not.[57] Almost immediately after Health's take-over, dues were raised to two cents per registered ton, collected not more than three times a year but amounting to never less than two dollars per ship in any year. The funds were paid into the consolidated revenue of the country, and a sufficient sum was voted by the government to meet its obligations in this field.[58]

By payment of the compulsory levy, the master of the ship received the right to send any sick mariner to any hospital for same at any time of the day or, in an emergency, any hour of the night. Upon signed approval by a Department official, the seaman received free treatment for one year unless suffering from permanent insanity. Care was only extended past one year upon written authority from the Minister. All types of disease were cared for, including venereal diseases and tuberculosis.[59] In reality, the Division only had two marine hospitals, both in Nova Scotia--one at Sydney and the other at Lunenburg. These clearly could not care for the large numbers needing the service--in 1926 alone numbering 3782 injured or distressed sailors.[60] To care for the overload, the Department entered into contracts with other government hospitals, general hospitals, infectious disease hospitals, sanatoria, nursing homes and, in outlying districts where no hospital accommodations were to be had, with private homes.[61] In places such as Canso, Nova Scotia, a doctor was given a fixed yearly rate to care and provide drugs for any mariner who might be laid up in his port.[62] The service was a consistent money-maker for the government, dues regularly exceeding the amounts actually paid out.[63] The Division simply took the money voted it each year and applied it to the care of sick mariners.[64] No innovative health policies were involved.

The one hold-over division that did evidence real innovation during the tenure of the Department of Health was the Immigration Medical Service. Canada passed its first immigration act in 1869, largely to protect itself against entry of such undesirables as lunatics and idiots. By 1902, immigrants with loathsome, dangerous and infectious diseases were also debarred. In 1903, medical inspection was introduced at the ports of Quebec, Halifax, Saint John, Montreal and at

Winnipeg. Three years later, new regulations made the proscriptions more precise. Prohibited were the feebleminded, idiots, epileptics, the insane, the deaf, the dumb, the blind, the infirm and those afflicted with diseases possibly dangerous to the public health. The version that the new Department took over in 1919 was the Immigration Act of 1910 which divided ineligible would-be immigrants according to three broad categories encompassing contagious disease, physical defectiveness and mental defectiveness.[65]

By this time, contagious disease was the least of Canada's immigration problems. The minor infectious diseases were easily cared for at the three Immigration Hospitals operated by the Department at Halifax, Saint John and Quebec City.[66] Of the five major quarantinable diseases, human plague had probably never entered Canada at any time; cholera had not been found on board a vessel in a Canadian port since 1871; typhus had not been detected on a ship heading for Canada since 1915 and was not likely to make an appearance due to obligatory delousing of all would-be immigrants; yellow fever had all but disappeared along with the sailing ships; and smallpox, although discovered almost yearly on ships in Pacific ports, could be forestalled by vaccination.[67] The most persistently irritating infection the Immigration Medical Service had to deal with was trachoma, a chronic eye disease that could lead to blindness. Some cases were refused entry into the country[68] while others were given three to six months treatment in immigration hospitals.[69] During the 1920s, the disease spread throughout the western provinces, attacking particularly the Indian population.[70] By February 1928, the disease was no longer treated in the Department hospitals, all cases found were deported on arrival and no person who had had trachoma in the past year was allowed to immigrate.[71] In large part, however, infectious diseases less serious than trachoma were seen as problems that could be cleared up after immigrants had entered the country. Although the best policy was considered to be that of not allowing new Canadians to live together in large ethnic groups which allowed them to hold on to what were regarded by health officials as unhygienic communal habits, the more feasible remedies of health education, public health nursing, "fathering" and threat of police action were applied.[72] The decline of the old communicable diseases[73] did not however mean the decline of the Immigration Medical Service. As late as the beginning of the Second World War, the Service was described as "performing one of the most important public health activities of our Government."[74] Because, although immigrants might no longer threaten Canadians physically, they still could do so economically and socially.

The last two classes of proscribed immigrants were considered undesirable not so much because they spread disease as because they were in danger of becoming public charges could they but slip past medical officials. Even if caught at the port before entry, Canada had to pay for their keep before deportation could be completed.[75] Theoretically, shipping companies were responsible for the state of health of all immigrants they allowed on ship. Practically, this was not always the case. The passage paid by an unfit emigrant was the same as that paid by one who was fit. Unscrupulous companies did not go out of their way to save the Canadian government money.[76] Even scrupulous companies might bring in people that would become public charges. Pregnant women well at embarkation might be ill by the time they docked;[77] many immigrants, especially those receiving assisted passage, were eager to hide their afflictions; [78] and accidents and emergencies such as appendicitis or pneumonia could occur unexpectedly on board ship.[79] The larger companies ran camps at European ports where all prospective emigrants were examined, vaccinated and de-infested.[80] Motivated not solely by government regulations, such companies feared that having large numbers of their passengers turned back after great personal expense would be bad for their business.[81] After legislation was passed in the mid-1920s levying a fine of two hundred dollars on steamship companies for each passenger requiring deportation because of failure to pass the medical exam, even the smaller companies began to protect themselves by stipulating examination by a line doctor of all emigrants they carried and by providing a port doctor who stood at the gangplank perusing for quarantinable diseases all passengers coming aboard.[82] Obviously, deportation also amounted to personal disaster for the deportee and an amendment to the Immigration Act in 1923 allowed emigrants in some areas to seek medical certification by a convenient Canadian-approved doctor before uprooting themselves. In the case of unaccompanied women and government-assisted passengers, this exam was compulsory.[83]

The Department of Health had taken over the Immigration Medical Service from the Department of Immigration and Colonization on 1 September 1919, just at the time when the termination of the war was leading to increased immigration. Complaints had already been levelled against loose enforcement of the medical regulations leading to a "somewhat unsatisfactory state of affairs."[84] A particularly touchy problem was that of pensioned British war veterans whom medical inspectors were letting by out of feelings of sympathy and patriotism. This situation finally became such that Amyot was instructed by the Department of Immigration and Colonization to order examining officers to tighten up the regulations before too many disabled pensioners became a drag on the government.[85] But the really fundamental concern was population of the country by the feebleminded. The general consensus of opinion among public health officials and reformers alike was that Canadian institutions were crammed with foreign-born defectives.[86] To complicate matters, mental defectiveness was regarded by certain people as not only definitely hereditary but even vaguely contagious. The frightening thing about the first notion was the prospect of the defective population multiplying rapidly through procreation. The solution proposed here was that each family should have to outline its medical history so that if mental problems occurred later, deportation would be facilitated.[87] The second problem was rarely overtly stated; still, it pervaded the general thinking on feeblemindedness at the time,[88] despite assurances to the contrary from the Department of Health.[89]

The real question, heredity and contagion aside, was who was to care for these people. Keeping sick people out of the country was a federal responsibility, caring for them once they were in was under charge of the provinces and the municipalities.[90] In effect, this meant that the provinces--especially the western ones where most immigrants were going and which had the least-developed social institutions to deal with them[91]--paid for federal mistakes. The Department of Immigration and Colonization, only as an adviser to which Health functioned in this matter, attempted to solve this problem by asking the provincial health departments for the names of candidates to fill the post of medical examiner.[92] But the provinces wanted much more--to wit, the right to re-examine all immigrants and to demand deportation of those who did not pass muster.[93] By mid-decade, the provincial health representatives on the DCH made a firm demand for "[establishment] of more rigid safeguards against the entry into Canada of mentally diseased or mentally defective persons."[94] Amyot convinced them that not just the Council or the provincial health departments must make this demand but that they must be backed up by the provinces themselves.[95]

The provinces had reason to complain. Medical examination of immigrants was casual. The method inherited by the Department of Health from Immigration and Colonization started by having the consignment of immigrants walk a maze.[96] The examiner stood at the head of the line and scrutinized the lot, "beginning at the alien's feet when he is about ten feet away and marching toward the examiner and ending by the turning of the eyelids, exposing the superior cul-de-sac and the examination of his scalp."[97] The officers had no specialized equipment. In fact, the eversion of eyelids was done with the help of steel glove and shirt buttonhooks generously, if somewhat amusedly, supplied by Tooke Brothers Limited of Montreal.[98] Suspect cases were put aside and after the examiners had finished primary line inspection, these people were given a more thorough secondary inspection, and were divided into those who should be released, those who should be deported and those who needed guarantee of support.[99] Two medical examiners working together were expected to go through as many as three hundred immigrants in one hour.[100] Officials recognized the impossibility of obtaining reasonable restrictions under this system. A disease such as tuberculosis simply could not be picked out by looking at a person and even if a more thorough exam was undertaken, cases that were merely arrested were undetectable.[101] Even worse, inspectors were sometimes forced to ignore some of the meagre measures stipulated by the statutes. In a letter to Amyot pleading for better conditions, Pagé asked that "Daylight Inspection" be enforced as provided for.

> Daylight is necessary to enable an Immigration Inspector to appreciate the significance of the hue of the people passing before him when it may be the only sign that may lead him to detect some serious underlying conditions.
>
> It is equally important for the examination of the eyes as artificial light tends to exaggerate certain affections of the conjunctiva and thus cause unnecessary detentions which could be avoided by an examination with natural light.
>
> Thirdly, and above all perhaps, the experts in mental defectiveness agree that it is an absolute impossibility to make a fair examination of a child's mentality on the approach of bedtime, as even grown people look more or less stupid while kept up when they want to sleep.[102]

There were additional special tests for feeblemindedness, notably the Binet-Simon Intelligence Tests applied from 1920 on.[103] However these did not prove satisfactory. "Many of those who were rejected under the tests were found to be quite normal in every respect, while others who were admitted were subsequently shown to be mentally deficient."[104] And examiners generously admitted that failure of the tests often did not demonstrate so much low mental calibre as the inability of immigrants to have found "the opportunity of educational training in their own politically unsettled countries."[105]

The Department of Health was aware of the problems and ever since its inception had taken steps to remedy matters. As soon as the Department was formed in 1919, a medical officer from the Immigration Service was posted to London to advise the Department of Immigration and Colonization. A second officer was appointed in 1924 but advisory status soon proved to be inadequate.[106] The Department provided for training of its officers in the slack winter months by sending them

> . . . to tuberculosis sanatoria so that they will be trained in picking out incipients, and apply same with the methods of examination of the tuberculous patients. We have sent them to psychiatric institutions, and to institutions in Toronto and Montreal, with the idea of showing them what to look for and to pick it out quickly. We have, we think, developed a staff that can judge pretty well what is coming through.[107]

Others went to clinics to accustom themselves to the various types of skin diseases[108] and some were even sent to Budapest to study trachoma.[109] Increased use of the alternative of deportation was also given consideration.[110] But, while theoretically anyone showing clinical signs of TB, a defective mental condition or a loathsome disease could be deported within three years of immigration,[111] practically such a move was made difficult by problems of diagnosis[112] and humanitarianism.[113] The best solution for all concerned was a more thorough examination--one done at or close to the port of embarkation.[114]

Voluntary overseas immigration medical examination was made possible by an amendment to the Immigration Act in 1923.[115] The system was part of a new drive to bring increased immigration,[116] especially by farmers.[117] Although the European ports were still often a long way from the emigrant's home,[118] such voluntary examination avoided the heartbreak of selling up and shipping out only to be returned, penniless, to one's homeland. Amyot, himself, went to Europe for two months in late 1924 to investigate the various problems involved.[119] By this time the United States had already established a system in Great Britain whereby all emigrants presented themselves for extensive exams at consular offices and had only to pass a cursory exam when landing in New York City, rather than spend time at Ellis Island. The European continent was now asking for the same privilege. The first step in Canada's new scheme was a network of 1500 (British) doctors scattered throughout

Great Britain, to whom the emigrants could go at their own expense. There is no question that this system kept back many immigrants that otherwise would have gained entry into Canada. During 1925, seventy-five percent of would-be immigrants received an exam only upon landing. The other one quarter of prospective Canadians were 20,000 who received the preliminary exam in Great Britain. Of these, 1500 were certified defective by the roster doctors and their certificates sent to civil emigration officers in London for final decision on acceptance or rejection. The Department felt the exam in Great Britain was six times as efficient as that made on arrival and "had the examination of all immigrants been carried out on the other side [Canada] as thoroughly as that of the 25 per cent, there would have been over 3,000 people prevented from coming forward."[120]

There were problems with this system. For one thing, its appearance of efficiency may have been inflated by the fact that prospective immigrants, unsure about their standard of fitness, were more likely to go into town on spec than they had been to cross the Atlantic Ocean. Doubtless, the roster doctors simply saw more inadequate specimens. Preliminary examination of all would-be immigrants would put this in perspective. Another problem was that, although all roster doctors were issued with quarantine and immigration regulations, it was doubtful that they really understood "our point of view--Canada's needs and what Canada wants."[121] In addition, there was the question as to who should pay the $2.50 fee for such a voluntary exam--the emigrant who was saved the personal expenses of deportation or the government which at best saved the financial expenses of deportation and at worst those of supporting a defective new citizen.[122] And the touchiest aspect was that such a roster ignored what was regarded as the biggest pool of defectives--the population of central and eastern Europe.

> To put that arrangement in force with regard to our own kith and kin in the British Isles, and not enforce same in Europe is, to say the least, somewhat nonsensical. If there were any restriction at all placed upon immigration, I would put them [sic] with regard to race. I would make immigration to Canada for a while almost entirely restricted to the Nordic race.[123]

Plans for a more thorough system were underway by the late summer of 1925.[124]

The Overseas Immigration Medical Service went into operation on the continent in October 1927 and in Great Britain in January 1928.[125] At a salary cost of $3000 to $3480 per annum with $660 to $900 living allowance, the Canadian government maintained a total of about twenty-eight medical officers[126] at London (the administrative centre), Liverpool, Bristol, Birmingham, York, Newcastle, Glasgow, Aberdeen, Belfast, Londonderry, Cork, Cardiff, Paris, Antwerp, Rotterdam, Bremen, Hamburg, Danzig and Riga.[127] The service was easily established on the continent as the precedent already existed of all continental migrants being required to obtain a visa before sailing.[128] Matters were more delicate in Great Britain. Organizations such as the Barnardo and St. George's Homes were accused of sending "foreign born defectives" to Canada.[129] Incensed, the British press led a campaign against the new medical inspection, calling it a restrictive measure.[130] The number of prospective British immigrants to Canada did drop off after the compulsory system came in but the same applied to immigrants to the United States and the other overseas dominions, which had no similar test.[131]

In truth, the system was set up to the distinct advantage of British immigrants. In Britain and the Irish Free State, the roster doctor system was extended so that no one had to travel more than fifteen miles from home to have the exam performed.[132] The report was sent for scrutiny to a Canadian medical officer[133] and if nothing appeared amiss persons could expect to have no further exam when they arrived in Canada as long as they did so within four months[134] and manifested no untoward clinical signs at that time.[135] It was true that there was no appeal if any applicant were turned down[136] but, despite British opposition, it is obvious that the Department went out of its way to make it easier for Britons to immigrate to Canada than for anyone else. Scandinavians still had to risk the crossing before they were examined[137] and James A. Glen, a member of the Immigration Committee, speaking on immigration policy in 1929, assured the House of Commons that it was much harder for a continental to immigrate to Canada. Whereas a Briton could get the exam close by and return home for two or three months to make the necessary decisions and plans, the continental had to report at one of the designated ports.

> He must go to the port some days before sailing takes place in order to give plenty of time for the examination. The difference in the medical examination itself certainly does not favour the continental. If British migrants had to go through the same form of medical examination as central Europeans go through at ports of sailing, I can assure you that we would have very little British immigration. If the continental immigrants are not fit they are returned, so that if the immigrant has sold his place and paid his fare for himself and his family to these ports, and then is found medically unfit, he can be turned right back at these ports.[138]

The Medical Officers conducting these exams were employees of the Department of Health and acted only in an advisory capacity to the Department of Immigration and Colonization. It was up to that division of the government to decide what action to take on the basis of the results.[139] The exam was considerably more thorough than the old "line inspection." It started out with the taking of complete personal and family histories regarding insanity, epilepsy, mental deficiency, tuberculosis, accidents, injuries and illnesses of any kind. All immigrants were examined for diseases of the central nervous system, lungs, heart, blood vessels, skin and special senses. Particular attention was paid to the presence of physical defects, especially of the feet and legs. It was not an easy exam to perform.

> The work of our Medical Service is based on an entirely different conception of medical examinations from that of the medical practitioner. A patient comes to him for help and offers unlimited assistance in the way of history of aches and pains, real or imaginary, physical or mental. We examine an unwilling witness who has no wish or desire to injure his case by disclosing what he would readily tell our practising confrères. We are, more or less successful, medical detectives. . . .
>
> All applicants are required to strip to the waist and remove shoes and stockings. The examination of men is carried further by dropping the trousers to the ankles, but women are not completely undressed unless there is some indication of the necessity for further investigation.[140]

To satisfy complaints that such an exam by an unfamiliar doctor was especially humiliating for women, female attendants were made available if no examiner of that sex could be provided.[141] Statistically the exam was outstandingly effective at keeping what were defined as undesirable immigrants out of the country. In 1929, under the European exam, 10,907 persons were prevented from coming for reasons of physical or mental defects.[142] The Service survived the amalgamation with Pensions and National Health. Despite falling immigration during the Depression and then the war, it would also survive, in virtually unchanged form, the shift to National Health and Welfare.[143] Keeping sick people away from healthy citizens remained unchallenged as a vital federal contribution to the public health.

The same can be said in the field of keeping sick-making things away from Canadians. The remaining two Divisions transferred to the new Department of Health--those of Food and Drugs and Proprietary or Patent Medicines--dealt with this problem. It is true that both were intimately tied in the establishing bill with a long-desired innovation, that of a medical research laboratory for Canada. Correspondence to the federal government asking for the establishment of the Department specifically asked for such a lab.[144] The Dominion Council of Health came out strongly in favor of special attention being turned toward this project.[145] Indeed, a Medical Research Laboratory was set up in late 1921 and was functioning a year later with two staff in bacteriology. However, it was soon realized that, due to the demands of the Food and Drugs and the Proprietary or Patent Medicines Acts, research would be pushed to the background. Plans were altered to give it the features of a control laboratory to scrutinize potency of sera, other biological products and certain drugs. By 1923, a pharmacological laboratory was added, operating along the same lines as the National Institute of Health in Washington, D.C. Failure in the field of research was acknowledged by the time a change of name--to the Laboratory of Hygiene--was made that same year.[146] Although it occasionally took on special projects such as an investigation of oyster beds in 1926 and clam beds in 1927,[147] basically it just stuck to general lab work for the whole Department.[148] Always cramped for space and short of staff, the lab could devote only inconsequential effort to research. The year of the amalgamation of Health and Soldiers' Civil Re-establishment, Peter McGibbon, a regular critic of federal health policy, bitterly expressed in the House of Commons the disappointment of those who had expected the promises of innovation in this field to be carried out.

> At the time of the organization of the department, Sir, we pressed for a department of scientific research, and it was promised to us. What has been done to redeem that promise? True, the Department of Health undertook a few routine duties, made a few good positions, and increased the salaries, but as a scientific organization the body of men assigned to that work have done nothing; the organization has been futile, it has been dead. I should like to see somebody put some life into those dead bones and make the organization as useful to this country as undoubtedly it could be made.[149]

Research would not fare better under Pensions and National Health. The Food and Drugs Act was revised considerably that very year, loading even more of the old routine analysis onto the lab of hygiene.[150]

The Food and Drugs Division whose existence defined that of the laboratory had its beginnings in the first Adulteration Act in Canada which came into effect 1 January 1875, providing for public analysts in the cities of Montreal, Quebec City, Halifax, Saint John and Toronto to study samples of food and drugs sent to them by collectors of Inland Revenue.[151] In 1884, a separate Branch was created under Inland Revenue to coordinate the work. In 1915, it was transferred to the Department of Trade and Commerce[152] and on 1 September 1919 was turned over to the new Department of Health. Its responsibilities fell into two categories--police work and investigatory work. For the first it supplied evidence for convictions; for the second, data to establish standards.[153] In addition to the central lab in Ottawa, there were sub-laboratories at Halifax, Winnipeg and Vancouver and later at Toronto and Montreal.[154] Almost immediately, the old Adulteration Act was repealed and superseded by the Food and Drugs Act, 1920.[155] The major difference under this new Act was that adulteration was clearly differentiated from misbranding, but only in the case of food, not drugs.[156]

The particular activities of the Food and Drugs Division were varied. It headed a Board for the Establishment of Food Standards.[157] It re-interpreted the *British Pharmacopeia*, the standard for purity, quality and nomenclature used by all druggists in Canada, to the Canadian situation.[158] It examined, licensed and controlled biological products such as Salvarsan and set physiological standards.[159] It investigated the effects of metal coming into contact with certain foods and thereby causing food poisoning;[160] analysed disinfectants for adequate amounts of carbolic acid;[161] set regulations regarding the relative proportions of gelatin and cream in ice cream.[162] On the legal side, Dominion analysts testified in court during prosecutions for adulteration and misbranding,[163] and Division inspectors were important enough to be occasionally impersonated or offered bribes.[164] Still, the powers of the Division had some limits. When asked to rule on the licensing of a certain germicide in 1924, the Dominion analyst had to reply that this could be done neither under the Food and Drugs nor under the Proprietary or Patent Medicines Acts as it had never been definitely decided whether insecticides and germicides were medicines and therefore there was no legislation to control them.[165] In 1927, prohibition of misbranding was extended to drugs. Under this restriction, no one was allowed to make "false, misleading or exaggerated claims, by word, design or device, both directly and by inference."[166] As part of this, it was now illegal to sell remedies for tuberculosis, cancer, diabetes and goitre, as no specific cure had been proven for any of these. The new Act attacked all sorts of quackery.[167] The activities of the Food and Drugs Division were not affected by the amalgamation with Pensions. In fact, the fierce competition for markets for drugs and the entry of the uninformed small business person into the provision of food during the Depression brought about increased work for inspectors and lab technicians alike.[168]

Although its concerns seemed frequently to overlap those of Food and Drugs and although they both used the same laboratory, Proprietary or Patent Medicines remained a separate branch throughout the various stages of the federal department in charge of health. Transferred to the new Department on 1 September 1919 from the Department of Trade and Commerce[169] which had been in charge of the Proprietary or Patent Medicines Act since it was enacted in 1909,[170] the new Division set about enforcing the amended Act. The new amendments regarding registration, licensing and relicensing were so far-reaching that it was necessary to pass an Order in Council in September 1920 allowing the great backlog of preparations already packaged and ready for the consumer, to be marketed until 1 January 1924.[171] Briefly the Division's duties covered the registration and licensing of all medicines meant for human internal and external use. Such medicines were allowed to contain neither opium nor cocaine nor alcohol in excess of the amount necessary to act as a solvent.[172] Manufacturers of such drugs were allowed to keep their formulae secret but the Division existed to ensure that no fraudulent claims were made about the worth or utility of the ingredients that were used.[173] No preparations were allowed registration if they purported to treat diseases that were considered to require medical supervision--for example, goitre, gallstones, Bright's disease, high blood pressure, pneumonia, tuberculosis, scarlet fever, diphtheria, typhoid fever, tumors, cancer, ruptures, obesity, diabetes, arteriosclerosis, venereal disease, appendicitis, infantile paralysis, spinal meningitis, erysipelas or epilepsy. Neither could substances claiming to restore virility or to induce abortion be sold. Advertising was regulated and the distribution of free samples from door to door--which could lead to abuse or in the case of the curious child, death--strictly prohibited.[174] Proprietary or Patent Medicines experienced a crush of business during the Depression for the same reasons as did Food and Drugs--fierce competition for sales and inexperienced small-scale manufacturers. It too survived World War II and the amalgamation with Welfare.

During the nine years of its existence, the federal Department of Health did an adequate job of taking care of the old divisions it inherited from other government agencies--Quarantine, Marine Hospitals, the Immigration Medical Service, Food and Drugs and Proprietary or Patent Medicines. All fitted neatly into the concept of federal government responsibility for public health through the relatively passive method of quarantine. The Department would not fare so well in those Divisions meant actively to promote health. By the time Health joined Pensions in 1928, both were merely caretakers--the latter of soldiers left over from the Great War, the former of leftover reforms.

NOTES

[1] Commons, *Debates*, 1919, p. 1169.

[2] *Ibid.*, p. 1167.

[3] *Ibid.*, p. 1172. This was a sore point. Up till this time the Department of Agriculture had headed the Dominion lab investigating and supplying sera and had maintained inspectors to investigate outbreaks of disease in humans and animals, alike. It was felt that humans had been short-changed by this arrangement. "Naturally the Minister of Agriculture has wished to spend money on horses, cattle, sheep and pigs--anything that has commercial value, but has looked upon the life of the human being as having no value at all." L. G. DeVeber; Senate, *Debates*, 1919, p. 294.

[4] Commons, *Debates*, 1919, p. 1171.

[5] *Ibid.*, p. 1170.

[6] Edmond Proulx, *Ibid.*, pp. 1182-4.

[7] PAC, RG 29, vol. 19 (file 10-3-1, part 2).

[8] Montizambert to Bryce, Secretary of the Provincial Board of Health of Ontario, 20 January 1902. PAC, RG 29, vol. 19 (file 10-3-1, part 1). This file contains correspondence on the establishment of a health department to 1912. RG 29, vol. 19 (file 10-3-1, part 2) contains correspondence on the same topic post-1912.

[9] PAC, RG 29, vol. 19 (file 10-3-1, part 2). Montizambert to Francis H. Gisborne, Parliamentary Council, 14 January 1919.

[10] At the same time, the fact that women were meant to work inside the home was demonstrated by the fact that they had been endowed with eyebrows to keep sweat out of their eyes. He therefore exhorted them to carry on "wielding the broom," although presumably not lustily enough to raise the dust which could so easily infiltrate their ineffective olfactory defences. F. Montizambert, "Hygiene and Sanitation: Domestic, Municipal, National and International." Offprint from the *Dominion Medical Monthly* (July 1908), pp. 5-6. Presidential address delivered before the Canadian Medical Association in Ottawa, 10 June 1908. PAC, RG 29, vol. 19 (file 10-3-1, part 1).

[11] Charles R. Maundrell, "Indian Health, 1867-1940" (unpublished M.A. thesis, Queen's University, 1941), p. 6. George Graham-Cumming, "Health of the Original Canadians, 1867-1967," *Medical Services Journal Canada*, XXIII (February 1967), 124-5.

[12] PAC, RG 29, vol. 19 (file 10-3-1, part 2). Plan for organization of Department of Health, 15 March 1920.

[13] *Ibid.*

[14] J. A. Calder, Commons, *Debates*, 1921, p. 3128.

[15] J. J. Heagerty, "The Retirement of Lt.-Col. John Andrew Amyot, C.M.G., M.B., Deputy Minister of Pensions and National Health, Canada," *CMAJ*, XXVIII (May 1933), 544.

[16] Commons, *Debates*, 1920, p. 263.

[17] PAC, RG 29, vol. 19 (file 10-3-1, part 2). "Returned Man is Appointed Health Chief," newspaper clipping, unnamed, undated.

[18] *Ibid.*, vol. 41 (file 35-3-1, part 1), Paylist of the Department of Health, 1921-22.

[19] *Ibid.*, vol. 19 (file 10-3-1, part 2), Secretary of the Treasury Board to Thomas Mulvey, Under-Secretary of State, 30 December 1919.

[20] *Ibid.*, Amyot to Secretary of the Civil Service Commission, 11 February 1920.

[21] *Ibid.*, Memo from the Clerk of the Privy Council, 2 August 1919.

[22] *Ibid.*, Untitled, undated type-written report.

[23] *Ibid.*, P.C. 1627, 2 August 1919.

[24] Canada, *Report of the Department of Health* [hereinafter *Report, Health*], *1920*, p. 9.

[25] PAC, RG 29, vol. 41 (file 35-3-1, part 1 and part 2).

[26] *Report, Health, 1920*, pp. 5-24.

[27] H. S. Béland, Commons, *Debates*, 1925, p. 3606.

[28] PAC, RG 29, vol. 41 (file 35-3-1, part 1), Appropriations for the fiscal year 1921-22.

[29] *Ibid.*

[30] *Report, Health, 1920*, pp. 5-6.

[31] For the various versions of the Quarantine Act and its amendments see PAC, RG 29, vol. 295 and 296 (files 410-2-1, parts 1 to 4).

[32] *Ibid.*, vol. 23 (file 21-1-1). J. J. Heagerty, Activities of the National Health Division, Department of Pensions and National Health, [17 January 1933?], pp. 2-3.

[33] PAC, DCH Minutes, 5th meeting, 19-21 October 1921, n.p.

[34] J. D. Pagé, "Grosse Isle Quarantine Station," *CPHJ*, XXII (September 1931), 458.

[35] *Report, Health, 1924*, p. 8.

[36] J. J. Heagerty, "Amendments to Canadian Maritime Quarantine Regulations," *CPHJ*, XXVIII (May 1937), 225.

[37] Canada, *Report of the Department of Pensions and National Health* [hereinafter *Report, PNH*], *1931*, p. 111. See PAC, RG 29, vols. 292, 293, 294, 298 and 299 for relevant files. Also DCH Minutes, 13th meeting, 8-10 December 1925, The Cyanide Disinfection of Ships, 3 pp.

[38] In 1931, eight vessels fumigated yielded 99 dead rats. *Report, PNH, 1931*, p. 114.

[39] See PAC, RG 29, vol. 290 (file 408-1-9, parts 1 and 2).

[40] In 1924. See *ibid.*, vol. 77 (file 416-2-2, part 5).

[41] See *ibid.*, vols. 764 to 771 for material on everyday administration of the Quarantine Division.

[42] *Ibid.*, vol. 41 (file 35-3-1, part 1). Correspondence among J. W. Reid, Audit Accountant; J. Anderson, Accountant of the Department of Health; and Dr. H. R. Nelson of William Head Quarantine Station, July and August 1921. Nelson finally replaced it at his own expense.

[43] Strong, p. 79.

[44] Pagé, p. 458.

[45] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 4. For the general files on leprosy see *ibid.*, vol. 768 (file 414-1-1, parts 1 to 4).

[46] R. E. Wodehouse and J. J. Heagerty, "The Health Section of the Department of Pensions and National Health, Canada," in Defries, *The Development of Public Health in Canada*, p. 149.

[47] PAC, RG 29, vol. 611 (file 30-1-4), Account of War Activities (of World War II) of the Department of National Health and Welfare [1947?], p. 77.

[48] *Report, PNH, 1931*, pp. 116-7.

[49] Wodehouse and Heagerty, p. 149.

[50] *Report, PNH, 1931*, p. 117.

[51] Wodehouse and Heagerty, p. 149.

[52] *Report, PNH, 1931*, p. 118. See PAC, RG 29, vols. 768 and 769 for relevant files.

[53] Wodehouse and Heagerty, p. 150.

[54] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 14.

[55] *Ibid.*, vol. 611 (file 30-1-4), Account of war activities . . ., p. 78.

[56] *Report, Health, 1920*, pp. 17-9.

[57] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 16. Wodehouse and Heagerty, p. 150.

[58] *Report, Health, 1921*, pp. 17-20. Wodehouse and Heagerty, p. 150. PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., pp. 14-5.

[59] *Report, Health, 1923*, pp. 16-22; and *1925*, p. 18. Wodehouse and Heagerty, p. 150.

[60] Strong, p. 80.

[61] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 15.

[62] J. A. Calder, Commons, *Debates*, 1921, pp. 3135-40.

[63] *Ibid.*

[64] For administrative files, see PAC, RG 29, vols. 772 to 773.

[65] Zlata Godler, "Doctors and the New Immigrants," *Canadian Ethnic Studies*, IX (no. 1, 1977), 8.

[66] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 5.

[67] Heagerty, "Amendments to Canadian Maritime Quarantine Regulations," p. 226.

[68] A group of about 400 Mennonites was refused the right to sail from Europe because 378 of its members were diagnosed as having trachoma. There was some discussion of whether they would be allowed into Canada once "cured" as they were considered particularly desirable immigrants. PAC, RG 29, vol. 287 (file 402-2-5), G. F. Black, Deputy Minister of Immigration and Colonization to Amyot, 26 September 1923.

[69] *Ibid.*, vol. 288 (file 402-7-1, parts 1 and 2), Memo from Pagé to Clark, 2 July 1920.

[70] For trachoma among Indians and in Manitoba, Saskatchewan, Alberta and British Columbia, see *ibid.*, vols. 288 and 289.

[71] *Ibid.*, vol. 288 (file 402-7-1, parts 1 and 2), Pagé to A. L. Jolliffe, Commissioner of Department of Immigration and Colonization, 13 February 1928. *Ibid.*, vol. 287 (file 402-3-2), Amyot to W. J. Egan,

Deputy Minister of Immigration and Colonization, 24 March 1928.

[72] PAC, DCH Minutes, 11th meeting, 15-17 December 1924, pp. 2-8, 15-9; 12th meeting, 11-13 June 1925, p. 2.

[73] The death rate from communicable disease, especially that in epidemic form, was reduced by two thirds between 1890 and 1914. C. E. Dolman, "The Health of the Nation," *CPHJ*, XXXII (August 1941), 395.

[74] Wodehouse and Heagerty, p. 149.

[75] H. B. Jeffs, "Overseas Immigration Medical Service," *CPHJ*, XXVII (June 1936), 282.

[76] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, p. 2.

[77] PAC, RG 29, vol. 287 (file 402-3-2), Pagé to W. R. Little, Commissioner of Immigration, 25 September 1919.

[78] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, p. 4.

[79] Hugh Guthrie, Commons, *Debates*, 1924, p. 4020.

[80] Such as that run by the Baltic American Line at Danzig. See PAC, RG 29, vol. 288 (file 402-5-8).

[81] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, pp. 10-1.

[82] *Ibid.*, 11th meeting, 15-17 December 1924, pp. 38-41; 13th meeting, 8-10 December 1925, pp. 3-4.

[83] *Report, Health, 1925*, p. 15. PAC, RG 29, vol. 287 (file 402-3-2) copy of the relevant "Pink Form."

[84] *Report, Health, 1920*, p. 7.

[85] See PAC, RG 29, vol. 287 (file 402-2-2). One particular case cited as an example of the type not to let in was an ex-soldier reported to be an "incipient case of Dementia Praecox." Among other symptoms, chiefly mild paranoia and suicidal tendencies, "[his] judgment is poor and his bodily development shows feminine characteristics, viz.--scarcity of body hair[,] feminine type of pelvi, a deposit of fat in breasts and hips, wears rings on index and second finger of right hand." W. C. Marriott of Department of Soldiers' Civil Re-establishment to Department of Immigration and Colonization, 31 January 1921.

[86] Alberta claimed that seventy percent of the 1076 mental patients in the province were foreign-born--29 percent from the European continent and 40 percent from Great Britain. Nova Scotia estimated that caring for 274 foreign-born patients in the preceding decade had cost $107,000. British Columbia counted 67 percent of its mental inmates to be foreign-born. (Similar statistics are quoted for other health problems. Ontario reported that most of those receiving TB treatment

had "foreign names.") See Godler, p. 13; PAC, RG 29, vol. 333 (file 436-3-3), E. W. Ryan of Ontario Hospital, Kingston to Amyot, 9 May 1921; *ibid*, vol. 39 (file 35-2-5, part 1), A. Grant Fleming, Deputy Medical Officer of Health, Ontario to Clark, 16 November 1923; DCH Minutes, 13th meeting, 8-10 December 1925, pp. 11-7; and J. H. King, Commons, *Debates*, 1928, pp. 909-11.

[87] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, p. 14.

[88] See PAC, RG 29, vol. 320 (file 435-7-11, part 2) and vol. 904 (file 437-5-11, part 1) for fears in this regard.

[89] "There is no question as to the fixity of feeblemindedness. A child who is feeble-minded will be a feeble-minded adult and a feeble-minded adult was a feeble-minded child. (Speaking in the general sense.)" *Ibid.*, vol. 333 (file 436-3-3), Clark to J. S. Fraser, Division Commissioner for Immigration and Colonization, 2 November 1925.

[90] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, pp. 52-3. William T. Lucas, Commons, *Debates*, 1928, p. 3964.

[91] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, p. 15.

[92] *Ibid.*, 6th meeting, 13-15 June 1922, p. 2 of Memorandum of Dr. John McCullough.

[93] PAC, RG 29, vol. 287 (file 402-3-2), Clark to F. C. Blair, Secretary of Immigration and Colonization, 15 April 1922. DCH Minutes, 7th meeting, 28-30 November 1922, p. 1; 9th meeting, 11-13 December 1923, Resolution 3; and 13th meeting, 8-10 December 1925, pp. 11-2.

[94] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, letter from Frances Tessier of Child Welfare Council, and DCH Resolution to Department of Immigration and Colonization.

[95] *Ibid.*, 14th meeting, 26-28 October 1926, pp. 21-2.

[96] *Ibid.*, 13th meeting, 8-10 December 1925, p. 2.

[97] Charles A. Bailey, "The Medical Inspection of Immigrants," *CPHJ* (no. 3, 1912), 435, quoted in Godler, p. 12.

[98] PAC, RG 29, vol. 288 (file 402-7-1, parts 1 and 2). Pagé wrote to the company 5 January 1922 asking if the Immigration service could have a dozen of these items which the company distributed as advertisements. "We may say that these have been found very useful and particularly suitable as a lid evertor in the examination of eyes for the purpose of detecting the existence of trachoma and other contagious diseases." Tooke Brothers sent five dozen and offered more. Pagé went so far as to send some of them to overseas officials of the Department.

[99] *Ibid.*, vol. 287 (file 402-3-2), Department of Health to McD. Morton, inspector at Halifax, 26 December 1919.

[100] PAC, DCH Minutes, 14th meeting, 26-28 October 1926, p. 2.

[101] Arrested tuberculosis may reactivate under stress. PAC, RG 29, vol. 287 (file 402-3-2), Clark to Blair, 15 April 1922.

[102] *Ibid.*, 27 December 1919.

[103] *Ibid.*, Clark to Clarence Farran of the Department of Soldiers' Civil Re-establishment, 27 January 1920.

[104] *Ibid.*, vol. 333 (file 436-3-3), Heagerty to Leslie G. Bell, M.P., 23 August 1928. These are the same tests that showed 47.3 percent of white drafted United States troops in World War I to have a mental age of twelve or less. Albert Deutsch, *The Mentally Ill in America* (New York: Columbia University Press, 1965), pp. 354-62.

[105] PAC, RG 29, vol. 333 (file 436-3-3), Chief of Quarantine to Edith Patterson of Calgary, 22 April 1927.

[106] Jeffs, p. 282.

[107] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, pp. 2-3.

[108] PAC, RG 29, vol. 333 (file 436-3-3), Clark to E. Ryan of the Ontario Hospital, Kingston, 3 April 1923.

[109] *Ibid.*, vol. 288 (file 402-7-1, parts 1 and 2), Amyot to all provincial medical officers, 25 April 1925.

[110] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, pp. 8-9.

[111] *Ibid.*, 8th meeting, 19-21 June 1923, p. 21.

[112] PAC, RG 29, vol. 333 (file 436-3-3), J. S. Fraser, Division Commissioner for the Department of Immigration and Colonization to Clark, 1 September 1925.

[113] "Ninety-five percent of the Russians that have come to this country are Jews, and you might just as well throw these Jews in hell as send them back to Russia. That is the cry they put up. I do not know that Russia refuses to take them back." Amyot. PAC, DCH Minutes, 13th meeting, 8-10 December 1925, p. 17.

[114] *Ibid.*, 6th meeting, 13-15 June 1927, Memorandum of Dr. John McCullough.

[115] PAC, RG 29, vol. 611 (file 30-1-4), Account of War Activities (of World War II) . . ., p. 77.

[116] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, p. 3.

[117] *Ibid.*, 11th meeting, 15-17 December 1924, p. 38.

[118] *Ibid.*, 9th meeting, 11-13 December 1923, p. 3.

[119] *Ibid.*, 11th meeting, 15-17 December 1924, pp. 1-2.

[120] *Ibid.*, 13th meeting, 8-10 December 1925, pp. 5-9.

[121] Amyot, *ibid.*, p. 6.

[122] *Ibid.*, p. 7.

[123] G. G. Melvin, Deputy Minister of Health for New Brunswick. *Ibid.*, p. 15.

[124] PAC, RG 29, vol. 287 (file 402-3-2), Notes of Conference held in the Office of the Deputy Minister of the Department of Immigration and Colonization, August 12th, 1925, 4 pp.

[125] Jeffs, p. 287.

[126] J. H. King, Commons, *Debates*, 1928, p. 3780. PAC, RG 29, vol. 41 (file 35-3-1, part 2).

[127] *Report, PNH, 1929*, p. 117.

[128] Jeffs, p. 282.

[129] W. L. Mackenzie King, Commons, *Debates*, 1928, p. 910.

[130] J. L. Ralston, Minister of National Defence, *ibid.*, p. 3928.

[131] W. F. Kay, *ibid.*, p. 3809.

[132] *Report, PNH, 1932*, p. 117.

[133] Jeffs, p. 283.

[134] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, p. 2.

[135] *Report, PNH, 1932*, p. 121.

[136] Strong, p. 90.

[137] *Report, PHN, 1932*, p. 118.

[138] Commons, *Debates*, 1929, p. 2760.

[139] *Report, PNH, 1931*, p. 120.

[140] Jeffs, p. 283.

[141] J. H. King, Commons, *Debates*, 1928, pp. 4059-60. There is, however, no evidence that women doctors were ever employed in the Immigration Medical Service.

[142] *Report, PNH, 1929*, p. 108.

[143] PAC, RG 29, vol. 611 (file 30-1-4), Account of War Activities (of World War II) . . ., p. 77.

[144] *Ibid.*, vol. 19 (file 10-3-1, part 1), Bryce to Montizambert, 30 September 1902, and (file 10-3-1, part 2), Federal Laboratories and Biological Products, unsigned and undated [1913?].

[145] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 1; 9th meeting, 11-13 December 1923, pp. 6-7.

[146] Norman MacL. Harris, "The Laboratory of Hygiene of the Department of Pensions and National Health," *CPHJ*, XXVIII (May 1937), 254.

[147] *Report, Health, 1927*, p. 64.

[148] *Ibid., 1928*, pp. 65-6.

[149] Commons, *Debates*, 1928, p. 700.

[150] Harris, p. 254.

[151] Wodehouse and Heagerty, p. 151.

[152] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 6.

[153] *Report, Health, 1920*, pp. 10-3.

[154] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., p. 6.

[155] *Report, Health, 1921*, p. 11.

[156] Wodehouse and Heagerty, pp. 152-3.

[157] The board had been created in 1909. PAC, RG 29, vol. 613 (file 339-5-2), Heagerty to Brown, 23 July 1934.

[158] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, pp. 4-9.

[159] *Ibid.*, 12th meeting, 11-13 June 1925, pp. 2-3.

[160] See PAC, RG 29, vol. 239 (file 335-4-1).

[161] *Ibid.*, vol. 39 (file 35-2-4, part 1), A. McGill, Dominion Analyst, to Amyot, 24 September 1920.

[162] PAC, DCH Minutes, 11th meeting, 15-17 December 1924, p. 38.

[163] *Ibid.*, 17th meeting, 19-21 June 1928, p. 38.

[164] See PAC, RG 29, vol. 256 (file 340-1-10).

[165] *Ibid.*, vol. 39 (file 35-2-5, part 1), H. M. Lancaster to Clark, 12 May 1924.

[166] Wodehouse and Heagerty, p. 153.

[167] For a general account of quack remedies, many of which were available in Canada, see James Harvey Young, *The Medical Messiahs. A Social History of Health Quackery in Twentieth-Century America* (Princeton: Princeton University Press, 1967).

[168] *Report, PNH, 1933*, p. 61.

[169] *Report, Health, 1920*, pp. 16-7.

[170] Wodehouse and Heagerty, p. 159.

[171] Each package was required to bear an official stamp of which over four million had been issued by March 1921. *Report, Health, 1921*, p. 17.

[172] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 3.

[173] *Report, PNH, 1932*, p. 97.

[174] PAC, RG 29, vol. 23 (file 21-1-1), Heagerty, Activities of the National Health Division . . ., pp. 11-3.

> . . . here is a department spending less than a million dollars; a large part is alloted [sic] to the payment of salaries, and absolutely nothing is being done so far as the public health is concerned. The minister himself admits that. . . . [There] should be a rattling of the dry bones in this department and . . . after this year something should be done to place it on a proper basis or else to put it [out] of business.
> --Martin J. Maloney in the House of Commons, 5 June 1928.

Chapter Three

THE PROMOTION OF HEALTH

NARCOTICS AND VENEREAL DISEASE, 1919-29

Canadian health reformers had called for something more than just quarantine. They wanted what J. S. Woodsworth described to the House of Commons as "[a] fitness that will enable men to give 100 per cent efficiency to their employers and the mothers to give 100 per cent efficiency in their homes."[1] This could not be achieved through mere disease prevention of the types provided by the inherited divisions. Higher hopes were held for the new divisions but by the end of the decade, Opium and Narcotic Drugs had unequivocally abandoned any guise of health provision for that of unadulterated punishment, Venereal Disease Control was trying to withdraw gradually from a campaign that too had turned away from disease control to social control, and Child Welfare had become bogged down in a wash of often unheedable advice. The other innovations--

housing, sanitation in various forms, hospitalization and statistics and publicity--would fare even less well, leading fitful existences of, in most cases, only a few years duration.

What was really needed to promote an adequate standard of health for Canadians was money. To his call for a standard of fitness, Woodsworth attached the need for a minimum income to define a state "below which no family can safely come."[2] The Department of Health had no way of providing for such an income. Neither could it provide utilities that would short-circuit the need for an adequate family salary. It could keep narcotics away from addicts and advise compulsory treatment but it could not provide the means for that treatment. It could help found venereal disease clinics but could not hold cases because all but the very ill and very poor avoided their "charity" atmosphere which allowed little of the dignity one could purchase from a doctor. It could advise pregnant women and mothers to seek medical help for themselves and their children but it could do nothing for those who could not pay for such help or for those who had no medical services nearby at any price. It also advised people to live in sound houses, to have good sanitary facilities and to go to clean, efficient hospitals. It even collected statistics to show Canadians what shape they were in and released publicity telling them how to better it. But none of these added up to an active health campaign. Many of the criticisms levelled at the Department were not precisely fair. It was not just to accuse it of doing "absolutely nothing . . . so far as the public health is concerned."[3] Its involvement in both narcotics and venereal disease control was not without success. It is simply that restrictions held it back from making a really significant contribution to the standard of health of Canadians. Unable to make a noticeable impact, it lost ground and revenue and, by 1928, independence.

The branch of Opium and Narcotic Drugs turned out to be the most robust of the reform divisions assigned to Health at its inception. Like the quarantine divisions it would outlast the Department. Canada had passed its first Opium and Narcotic Drugs Act in 1908 as a spin-off of Mackenzie King's report "On the Need for Suppression of the Opium Traffic in Canada," chronicling his findings as Royal Commissioner to investigate anti-Oriental riots in Vancouver in 1907. The Act prohibited all sales of opium.[4] This legislation, however, did not solve the problem. The most notable reformer calling for stricter control was Emily Ferguson Murphy. In her role as President of the Canadian Women's Press Club she wrote to Rowell on 3 December 1919 asking for information on the amounts imported under the Opium and Narcotic Drugs Act. She stated overtly that she needed the statistics for a series of articles she was doing. Two days later she solicited an opinion from Deputy Minister John Amyot on how best to treat returned soldiers who had become addicted, not through any criminal intent, but because of wounds and shell-shock. She expressed her concern that both addiction and drug trafficking were increasing in the western provinces.[5] Replies to Murphy were written by D. A. Clark in his capacity as Assistant Deputy Minister. In them, he made clear that the Department, as administrator of the relevant Act, intended, even before the Narcotics Division was established, to treat drug addiction as a criminal offence, not as a health problem. Murphy saw addicted veterans as casualties of war; Clark warned that those addicted after the war were simply long-time addicts who had slipped by enlistment authorities.

> It should also be borne in mind that, in spite of the hardship of service, the vast majority of those on service did not find the use of such drugs necessary. This would largely disprove the claim usually fraudulently put up by drug adicts [sic] that war service caused their habit. It may be taken for granted that a statement of this kind made by a drug adict [sic] is usually meant to appeal to public sympathy and is advanced as an excuse which may mitigate public disproval [sic] of his misconduct.[6]

Murphy's articles on drug abuse in Canada appeared first in *Maclean's* and were collected complete with additions in *The Black Candle.*[7] Racist and sexist, the book painted a picture that was truly black. It caused considerable chagrin not only among the federal officials who had so obligingly provided her with ammunition but also among provincial health officers who had to face down public outrage. In answer to a letter from the federal Department asking for an estimate of the number of drug addicts in Saskatoon, the medical health officer, G. M. Donald, said he would be happy to provide such for Department information but he was upset over a statement by Murphy that hundreds of Saskatoon's young people were addicted to cocaine. Angered at this slur on the youth of his city, Donald demanded to know who had issued such figures.[8] F. W. Cowan, in charge of the narcotics division, tried to smooth the waters. He deplored Murphy's estimates of 60,000 drug addicts in Canada and judged her guilty of sensationalism aimed at increasing the sales of her book. He insisted that Murphy had abused confidentiality and that release of information on his own part had all been an unfortunate error.

> Had I known Mrs. Murphy, as well, at the time, I furnished her with considerable information, as I do now, I can assure you that I would have been more cautious in my dealings with her.
>
> I can assure you that the Department is not interested in any propaganda advanced by any individual, or Society in connection with drug traffic.[9]

Murphy's charges were particularly galling because health officials were deeply concerned about the use of habit-forming drugs. In October 1919, the Dominion Council of Health discussed the matter at some length. During the war, *de facto* control had been in operation under the War Measures Act. Import and export of cocaine and its preparations, opium and its preparations or opium alkaloids and their salts and preparations were prohibited except under license issued by the Minister of Trade and Commerce. With victory came the necessity to make other provisions or see all control lapse. The Council considered three alternatives: government purchase for distribution to legitimate dealers; licensing for a limited number of wholesale houses; limiting the number of ports of entry. It opted for the first and passed a resolution unanimously recommending that the government take over entirely the importation of habit-forming drugs and distribution to legitimate dealers.[10] The Opium and Narcotic Drugs Division came into being on 1 January 1920.[11] As for the legal importation of such drugs, it was to control imports, exports, manufacture, sale and distribution of opium, morphine, heroin and cocaine.[12] As for illegal traffic, it cooperated with the Royal Canadian Mounted Police and the Department of National Revenue in prosecuting offenders, imposing fines and removing from the market preparations which contained large quantities of morphine and opium.[13]

There was a perceived need to control the legal importation of addictive drugs into Canada. While Murphy's sixty thousand drug fiends were considered to be figments of an inflamed imagination, Amyot did admit to a Toronto *Globe* reporter that a more conservative estimate of twelve to fifteen thousand addicts might be accurate.[14] And these were by no means all "criminal" addicts. Legal importation of cocaine, morphine and opium into Canada had risen significantly between 1912 and 1919.[15] These found their way into internal and external remedies alike. Soothing syrups and diarrhea cures, both given often to very small babies, could quite legally contain more than a quarter grain of opium or morphine to the ounce.[16] Such dosages were considered dangerous by some. Mrs. Winslow's soothing syrup, which contained between one half and one grain of morphine per bottle was accused, along with other similar patent medicines, of killing more children than did any disease.[17] Adult addicts sometimes used these preparations to satisfy their own craving. One case cited was that of "a married woman" in Winnipeg consuming ten to twelve bottles of Fowler's Extract daily. The expense finally became so exorbitant that her physician legally prescribed morphine for her instead.[18] Physicians' casual--though not criminal--attitude to prescription of narcotic drugs was unintentionally demonstrated by Peter McGibbon in the House of Commons during the debate on the new Opium and Narcotic Drugs Bill the Department was to administer. He declared himself absolutely opposed to the new restrictions which would prevent him from prescribing over the phone what he referred to as "household remedies"--i.e. tincture of opium.

> . . . there is not a week, when I am at home practising, that people do not telephone to me and complain of pains--symptoms of appendicitis, or colic or something of the kind--and I ask them if they have any remedies in the house. They tell me probably that they have some laudanum or paregoric, and I have prescribed it over the phone hundreds of times. If you are going to take away from these people the right to purchase such remedies, you are going to cause unknown suffering, and I would even go so far as to say, perhaps, death.[19]

The month before this debate, the head of the new federal division, F. W. Cowan, wrote to Dr. B. J. McConnell, the official in charge of narcotics control in Manitoba, complaining that import records showed that certain Winnipeg physicians and pharmacists were receiving "excessive" amounts of narcotics. He speculated that this legal trafficking was more extensive than that carried on by street peddlars.[20]

Physicians like McGibbon were not the only ones who felt they had reason to complain about the proposed restrictions. Manitoba druggists objected to what they also called "household remedies" being placed under federal control.[21] The Canadian Pharmaceutical Manufacturers Association submitted complaints to the Department, basing its arguments on economy.[22] Mackenzie King brought the opposition of retail pharmacists before the House. In answer, Rowell insisted that the "measure will not be proceeded with until after the Government has heard the representations which those who will be affected by the legislation wish to make in regard to it."[23] But although it did call a conference of druggists to discuss the new bill,[24] the government remained firm. A tighter system of legal supply of habit-forming drugs in Canada was to be introduced over all objections. The pharmacists did have reason to feel they had been singled out for punishment. By implication, they carried full blame for the old system of legal abuse. They were to be controlled but not the doctors.

> It is provided by this Bill that any retailer or manufacturer of drugs may sell to a practising physician any of these drugs. The seller has to keep a record of what he buys and of what he sells, but the doctor may obtain these drugs and dispense them to whomever he sees fit, without keeping any record. If any abuse occurs, there is no provision for suspending his license as practising physician or for the imposition of any other penalty. My opinion is that there ought to be some check on the physician--even if that view should bring down the thunders of the medical profession.[25]

The Department still had not sorted out its attitudes towards prosecution of doctors by the time the Act underwent a major revision in

1929.[26] In the meantime, druggists were expected to comply even before things were properly organized. L. A. Brown of North Battleford, Saskatchewan wrote to the head of the Division after its establishment asking for the special book in which he was to record all narcotics sales. Cowan replied: "You are advised that there is no special book or register that this Department is aware of, but that each druggist adopts a book or system to suit his individual requirements."[27] Even by the end of the decade, the control of legal supplies of narcotics was not foolproof. When the Canadian Credit Men's Association of Toronto bought out a pharmacy complete with narcotics in early 1928, it inquired of the Department what provision it must make for the distribution of these drugs. The correspondence that resulted was extensive and unrewarding.[28]

Part of the reason Canadian dissidents made so little headway in their campaign against narcotics control was because the country was obligated, as a member of the League of Nations, to initiate this legislation. Call for some sort of international control had been in existence for quite some time. Mackenzie King had represented Canada before the International Opium Commission in Shanghai in 1909 and the resolutions of this conference plus the United States' *Harrison Act* of 1914 were major factors in Canada bringing in more punitive measures.[29] The first major international attempt at worldwide co-ordination of narcotics supply was undertaken at the Hague in 1912. However, the Great War intervened and it was not until the second opium conference in Geneva in 1924-25 that concrete compacts were ratified. Amyot attended the earlier part of the conference and came back to report to the Dominion Council of Health in December 1924 that the conference was fraught with dissension.[30] The International Agreement arrived at provided for the licensing of all chemical manufacturers in Europe.[31] A central board was established in Geneva to which all signatories submitted annual estimates of narcotics needs. Once approved, these estimates were circulated to all countries to ensure that world transactions were kept within these limits. As a double check, each country had to furnish annual reports to the central board of its imports and exports under the Convention.[32] "In this way narcotics cannot be shipped to any country which has not previously indicated its desire to receive them."[33] In order to compile the statistics demanded of it by Geneva, the Division kept a staff engaged solely in entering on some eleven thousand personal cards--one for each physician, veterinary surgeon, dentist and retail druggist in the country--all narcotic sales made in Canada. Any unusually large quantity purchased by any of these professionals was checked immediately by Division staff to make sure that narcotics were not being used illegally or unnecessarily. At any given time, such correspondence was being carried on with approximately one hundred members of the medical profession.[34] Legal supplies seemed to be under control.

But there was another, illegal, side to narcotics supply that the branch viewed as very much out of control. In 1922, the annual report of the Department dealt for the first time with the problems of stopping smuggling and the illicit traffic in drugs.[35] In 1923, it reported not only on the amount of legal narcotics entering the country but also on precautions against illegal trafficking.[36] By the next year, the major part of the narcotics section of the report dealt with arrests and seizures.[37] By 1925, confidence in control of legal supplies had been vested in Geneva and the Division turned almost entirely towards aggressive police work.[38] Trafficking was seen not only as lucrative--so lucrative in fact that police in Vancouver were under suspicion and under investigation and the practices of certain doctors were being delicately probed[39]--but, to many, there appeared to be another side to the drug traffic. It was seen as part of a plot to subvert the Anglo-Saxon race. The Chinese were regarded as the greatest subversives and, indeed, far more Chinese were prosecuted for trafficking than anyone else. For the ten months ending 31 January 1923, 585 prosecutions were carried to conviction by the Department under the Opium and Narcotic Drugs Act; 431 of those convicted were "Chinamen."[40] It is likely that a great deal of the narcotics sold by these people went to their own compatriots; however, it is probable that, considering the extent of the traffic they carried on, some sales were to non-Orientals. Chief Constable James Anderson of Vancouver cited arrests for drug offenses in his jurisdiction over nearly a five year period. Of 2926 arrests between 1 January 1918 and 29 November 1922, 1930 had been of Oriental men. But even if it could have been proven that Orientals functioned in this matter in a tight cohesive group, making transactions only among their confrères, the drug trade would still have been seen as threatening to the white population of British Columbia. Chinese market gardeners were said to smuggle drugs into town among their vegetables. Money gained thereby helped them to undercut the prices of competitors in the gardening end of their operations.

> We might say that if the land was given to good Canadians and given a fair chance, they might make good, but it is hard at present for a Canadian to compete with the Chinese gardeners in this Province, as the chinaman lives as no white man could.[41]

These people were not wanted in Canada, not even in the gaols. Frequently, Chinese were granted clemency immediately after conviction so that they could be deported.[42]

The particular danger of Chinese and other aliens was not just that they supplied drugs to whites but that they dragged them down to their own level. Murphy's book specialized in these types of horror stories. Illustrated by pictures of young white women lounging affectionately with black men,[43] she trumpeted such warnings as:

> A man or woman who becomes an addict seeks the company of those who use the drug, and avoids those of their own social status. This explains the amazing phenomenon of an educated gentlewoman, reared in a refined atmosphere, consorting with the lowest classes of yellow and black men.[44]

Even in the 1930s, drug traffickers were referred to in Departmental reports by their ethnic origins. Canadian citizens or no, they were known to narcotics officers as Italians, Chinamen and Jews.[45]

Drug traffickers were not seen as catering to a demand so much as creating a need. Canada did not manufacture narcotics; therefore its problem was one of controlling their entry into the country--usually through the ports of St. John, N.B. and Halifax, N.S. in the winter and Montreal and Quebec City in the summer.[46] Try as it might, the Division could not prevent all smuggling.

> [Consequently], so long as, from a world standpoint, narcotics are available in a greater quantity than is required for the legitimate medical needs of the various countries of the world, obviously such greater quantity will be trafficked in by unscrupulous persons and problems created in various countries involving very considerable expenditures in the control and punishment of persons engaged in that deadly traffic.[47]

In other words, as long as there were drugs for sale, there would be addicts. The federal Department was doing its best to fight addiction by straining to keep narcotics out of the country. This paralleled precisely the federal activities in the border quarantine of communicable diseases. It also fought addiction by trying hard to keep these sick-making items away from Canadians once they had entered the country. This mirrored the activities of the Food and Drugs and Proprietary or Patent Medicines Divisions. But just as in these aspects of disease control, once drugs had entered Canadian bodies and made people ill, the problem was consigned to the provinces. Congratulating itself on how well it was holding up its end of the deal, the Department complained in 1926 that what was desperately needed was legislation to deal with existing drug addicts.

> The matter of providing for the treatment of such cases is, of course, one altogether for the provincial authorities to deal with, the same as they care for their insane, feebleminded, tubercular cases, and V.D. patients, etc.[48]

It reiterated the same opinion the next year.[49] It was still doing so at the end of the decade.[50] The conflict of federal versus provincial jurisdiction was raising its ugly head. Matters went to such lengths that in narcotics cases initiated by federal authorities, Dominion analysts were used and in those initiated by provincial or municipal authorities, they provided their own.[51] As it did in all Canadian health matters the separation of powers would prove arbitrary and defeating.

There was considerable debate about just how many addicts there were in Canada for whom some provision of treatment should be made. Cowan sent a form letter to the chief constables in various municipalities, 28-29 December 1922, asking for an estimate of the number of addicts in each jurisdiction. He also circularized public health officers on the same question as a double check. The answers received were unsatisfactory and even contradictory. One source said Regina had no addicts while another reported two recent convictions in that city.[52] Finally, by some unknown process, the Department settled on a total of 9500 drug addicts in Canada not under a doctor's care.[53] This was broken down into: British Columbia, 2250; Alberta, 350; Saskatchewan, 250; Manitoba, 500; Ontario, 1800; Quebec, 3800; New Brunswick, 250; Nova Scotia, 300; and Prince Edward Island, 0.[54] Addicts were seen as being of two distinct types--the criminal and the non-criminal. The former--the "dope fiends"--inhabited the cities.[55] This "underworld type of addict"

> spends a considerable proportion of his life in jail, either on narcotic charges or for other crimes usually committed in an endeavour to maintain a supply of the drug of addiction at the high prices now obtaining.[56]

A quasi-criminal element existing on the fringes of this underworld were such people as vaudevillians addicted to heroin.[57] The other type of addict was the respectable citizen who had become hooked while being treated for a disease that eventually caused death, or a decent person who through overwork, nervous dissipation or for a no longer existing disorder, had turned to narcotics for relief.[58] Although this distinction may have been clear in the public mind, it had no basis in law. This meant that if legislation were passed to compel criminal addicts to undergo treatment it would automatically apply to respectable addicts. This proved a knotty problem.

At the time of the establishment of the Division, most provinces had no laws at all dealing with narcotic drugs.[59] Nova Scotia and Alberta, in 1924, and Manitoba, in 1925, passed laws providing for voluntary or compulsory treatment of addicts,[60] but by 1926, only

Alberta had made any attempts at enforcement.[61] One reason for this was that there simply did not exist facilities to treat addicts. Urged by the Dominion Council of Health to discover "places where dope fiends may be treated,"[62] Cowan wrote to all provinces 29 November 1922 asking for the names of hospitals and institutions for drug addicts and of doctors specializing in their care.[63] The awful truth of the matter was that as late as the end of 1928 only a very few private institutions would take such patients.[64] As a rule regular hospitals did not want them because they were frequently obstreperous[65] and although some mental hospitals such as that at Ponoka, Alberta would take them in[66] others balked at the idea of admitting a disruptive patient over whose comings and goings they had no legal control.[67]

But addicts were also seen as a disruptive force in the community, especially if they held important positions, and the Department insisted they should be hidden from the public eye.[68] Where to put them was the problem. Gaol seemed hardly the solution. For the respectable addict it was considered too humiliating an experience;[69] for the criminal addict it was seen as fruitless because guards could be bribed to supply drugs.[70] Seemingly the only feasible solution was a special type of hospital but it would certainly have to be an institution of incarceration. Treatment was pretty well limited to cold turkey.[71] Withdrawal symptoms could be moderated by such synthetics as Narcosan,[72] but in the long run, kicking the habit was up to the patient. Obviously it would not be a pleasant experience and the Department maintained throughout the 1920s that people would not carry through to cure unless they were forcibly detained.[73] Still, although there is evidence that the Department was not dead against Dominion provision of such guarded hospitals from the first,[74] there is no evidence that it ever considered building an institution such as the United States federal narcotics hospital at Lexington, Kentucky.[75] Instead, the Department put pressure on the provinces to provide this type of treatment centre.

> There are a lot of people who, I think, could be cured--not the underworld type. We must realize, too, that the medical man can only do one thing for the addict. He can put him in the state where he has no withdrawal symptoms, but he cannot cure the type who is going back just as soon as he wants a little relief. That type of man you cannot cure at all. The only thing is to lock him up. But there are people not yet in the underworld who would really make a determined effort if there was some place to go for treatment . . . We ought to have some place in the provinces where they can be locked up, and the reason for the traffic would cease.[76]

Anyone regressing after release from such an institution--even the "higher type of addict"--should be gaoled.

> Fortunately most of these addicts of the better class are brought back to their families and are helped out by them. If they are the kind that go back then they are booked for the underworld, and the thing is then to take them into jails.[77]

Despite insistence of the Department and the efforts of at least one voluntary organization--the Anti-Narcotic Educational League[78]--such institutions were never provided. The reason was the usual one. The provinces had insufficient money and certainly none to spare on the correction of what they felt were federal mistakes.[79] While still calling for some sort of provincial treatment centres,[80] the Department tightened control on the part of the problem it clearly recognized as its own. The Opium and Narcotic Drugs Act was extensively revised in 1929. It was directly aimed at more severe suppression of trafficking. One of its provisions was for application of the lash at the discretion of the judge.[81] The Department of Health never managed to attack drug addiction as a health problem. Neither would Pensions and National Health.

It had considerably more success in breaking new ground when it came to the venereal diseases, probably because, while viewed as a major threat to all of Canada on a par with narcotics and defective immigrants, it was not so amenable to the old quarantine-types of solutions. Its place under federal responsibility was in some question but not in much. The federal argument was that, for this type of disease at least, treatment was prevention.

> As contagion is, in the vast majority of cases, direct; it is manifest that the greater the number of cases which are rendered non-infective, the fewer the number of new cases that will arise. Treatment is, therefore, not only beneficial to the individual but to the community.[82]

The only way the federal government could ensure the fulfillment of its duty--that of prevention--was to subsidize the provinces in the fulfillment of theirs--that of treatment. This is not to say that the Department did not make some attempt to solve the problem through the traditional quarantine-type measures. The federal government was under some pressure to keep out immigrants who might be spreaders of venereal disease. This applied directly to people actually infected with the diseases[83] and equally to mental defectives who were expected to pick up VD and pass it around.[84] Exclusion of mentally defective immigrants became a particular project of the Department's Immigration Medical Service[85] and, as requested by the provinces early in the decade,[86] diagnostic tests for both syphilis and gonorrhea were performed on prospective immigrants by 1928.[87] Treatment was also stepped up for mariners who might otherwise bring the venereal diseases into port.[88] In-country quarantine measures were also tried. In an attempt to keep infection from Canada's native peoples, an ordinance was passed to prevent sufferers from VD and other communicable diseases from entering the North-West Territories.[89] Consideration was given to placarding premises where these diseases were found as was done in the United States,[90] to segregating the infected until cured,[91] and even to deporting those inflicted with the "unmentionable diseases."[92] In the end, however, the most meaningful contribution the federal government made in this field was to provide funds for the establishment and maintenance of the provincial clinics.

Before the Great War, Canada probably had no more than two clinics devoted to the treatment of VD.[93] The federal government specifically asked the provinces to undertake more extensive VD work.[94] The provinces felt that they should not have to bear the expense alone as it had been a national catastrophe, the Great War, that was generally accepted as having exacerbated the problem.[95] Some provinces had already made moves towards fighting VD--Saskatchewan passing relevant legislation in 1917,[96] Alberta in April 1918[97] and Ontario in May.[98] But to satisfy federal demands, the provinces wanted federal assistance, both in the form of grants and in that of relaxation of customs duties on needed drugs and equipment.[99] The federal government complied with the latter request by late 1921.[100] Compliance with the former was contained in the first budget of the Department of Health. A grant of two hundred thousand dollars, one fifth of the Departmental budget, was to be used in the fight against the venereal diseases.[101] The Dominion Council of Health decided in October 1919 how this was to be divided up. Ten thousand dollars was to be kept by the Department to fund general organization of "The National Compaign Against Venereal Disease" and for the production of literature and propaganda, another ten thousand was to be signed over to the National Council for Combatting Venereal

Disease (later renamed the Canadian Social Hygiene Council and later still the Health League of Canada) which was to be the prime mover in education of the population, and the rest to be distributed among the provinces on a per capita basis. All provincial representatives expressed a willingness to provide matching funds but also a worry--as it turned out, with good reason--regarding continuity of the federal grant. Although Amyot opined that there would be no trouble in this connection, the provincial representatives unanimously passed a resolution that the annual grant be appropriated for at least three years, preferably longer.[102]

In return for federal assistance with what was supposedly a provincial responsibility, each province was to

> establish clinics for the free treatment of venereal disease; examine and treat all prisoners in jails; maintain laboratories; make free examination of smears, blood, etc.; undertake a campaign of education; formulate laws for the control of venereal diseases; and generally undertake the work of venereal disease control.[103]

For its part, the federal Department was to set up a Division of Venereal Disease Control headed by a chief who would co-ordinate and supervise the work of the provinces, to collect VD statistics, to inspect the clinics, and to conduct a campaign of education.[104] By May 1920, eight of the nine provinces (Prince Edward Island being the exception) had taken advantage of the grants and had started clinics.[105] The campaign in the more populous provinces was to be supervised by a full-time--in the less populous provinces, a part-time--"qualified medical man," preferably one who had gained experience in this particular work while overseas with the troops.[106] Early emphasis in the campaign was on trying to reach "one big group that is a source of infection, perhaps more than any other--the people who get into the hands of the law."[107] All inmates of gaols, prison farms, etc. were the first tested and treated and, under the provisions of the new provincial laws, held (if necessary, past expiration of their sentences) if not until cured, at least until rendered non-infectious.[108] In addition, these new laws provided not only for compulsory treatment of the incarcerated but also, under certain circumstances, for compulsory incarceration of the infected.[109] This link between infection and criminality proved to be a prominent and long-lived tenet of the Canadian venereal disease control campaign.

Canada was not the only country becoming concerned with the rumored prevalence of syphilis and gonorrhea. Great Britain had conducted a Royal Commission on Venereal Diseases between 1913 and 1916, the result of which had been funding for local clinics.[110] Australia's legislation of 1915 and New Zealand's of 1917 were used as a model for Canadian laws.[111] The United States provided a small grant for VD prevention during the 1920s.[112] Canada's concern, as that of the others, had been particularly sharpened by revelations of the extent of syphilis and gonorrhea among national troops and institutionalized civilians and by fears of a major post-war epidemic.[113] The federal government called a conference to discuss what was usually known as social hygiene for 3 February 1919 and at that time it was argued that the only way to fight the new enemy was by "compulsory, standardized . . . treatment of venereal diseases with prevention of quack treatment and infection and rigid rules as to notification."[114] These provisions sum up the problem nicely. The Canadian governments wanted to clean up venereal disease. The only way this could be done was through treatment.

To ensure treatment for that segment of the population considered to be the greatest pool of infection and at the same time the least likely to seek treatment, compulsion was to be applied. For more respectable citizens who might even have contracted the disease "innocently,"[115] compulsion was to be in the form of removing from sale all remedies for self-medication, forcing them to seek the care of a doctor, or if financial embarrassment outweighed personal, to go to a government clinic.[116] The governments of Canada were prepared to go to considerable expense to provide proper treatment. They expected it to be taken advantage of. But more than anything, what health officials and reformers really longed for was prevention of transmission through prevention of "promiscuity."

It was at prevention of this type that most of the educational work undertaken by the Department, the provinces and the Canadian Social Hygiene Council was aimed. From all appearances, this education carried very little information regarding the actual diseases. For various reasons--the "moral issue,"[117] the fear of putting ideas into children's heads,[118] objections from the medical profession about information on treatment actually being demonstrated directly to the public,[119] belief that the truth would make people sick[120]--the information doled out to the public was not very informative. Obfuscation was intentional. The point of the educational campaign was only incidentally to inform Canadians about the disease and how to prevent its contraction. The stress instead was on the necessity of avoiding any chance of catching a social disease.

> The object of education in this campaign is not so much the dissemination of knowledge of venereal disease as the development of standards of conduct and the formation of character . . .

> A knowledge of venereal diseases will not prevent illicit sexual intercourse nor its consequences; there must be, in addition, sound ideals which act as a basis for the control of sexual appetite.[121]

The Department disseminated information in two ways--via the written and the spoken word. Published information consisted of different types of pamphlets meant for different types of readers--doctors, parents, young men and women, sailors, etc.--and posters which it supplied gratis to the provinces calling attention to the dangers of the diseases and advertising the free clinics.[122] But it was Departmental lectures that must have reached most people. These were elaborate affairs.

> Our method of procedure is as follows: Through the co-operation of the Canadian Social Hygiene Council and the Dominion Department of Health, on Sunday night the most popular moving picture theatre in some town is engaged and the meeting advertised in the local newspapers and churches. The programme opens with "The Health Twins at Work," followed by "Social Protective Measures." A lecture is then given, dealing with various phases of social hygiene. As these lectures are for adults, a special effort is made to drive home to them the necessity for the education of boys and girls in the elemental principles of life as a preparation for their careers as citizens and parents. The provision of recreational facilities is stressed, the problem of prostitution and venereal disease, the relationship of immoderate and extravagant living and of excess of various kinds to present day unhappiness are discussed. Following the lecture, some of the slides from the series "Youth and Life" and "Keeping Fit" are shown. This programme gives two hours of instruction in an entertaining way. We believe that in this way the representative people of the community are influenced to take a greater interest in the problems of boys and girls. At times the programme is given as outlined to women only, and, at other times, to men only. This gives us the opportunity of reaching these groups with special types of lectures.[123]

Such lectures were also organized by the Hygiene Council in co-operation with the provinces. New Brunswick and the Council excelled themselves in 1923 when they sponsored a travelling camp meeting starring Emmeline Pankhurst. Planned since 1919,[124] the campaign travelled through most of the small towns of New Brunswick between 21 January and 4 February 1923. Everywhere, except Bathurst where the lectures competed unsuccessfully with a hockey match, Pankhurst, Gordon Bates for the Hygiene Council and Heagerty for the federal Department spoke to packed and even overflowing houses.[125] Dr. G. G. Melvin, New Brunswick's representative to the Dominion Council of Health, reported that the campaign had aroused considerable interest in the subject of social hygiene.[126]

The Social Hygiene Council also provided information on its own. Established precisely for that purpose in 1919, and at the instance of the Dominion government, the Council's *raison d'être* was to act as liaison for federal, provincial, municipal and non-governmental bodies fighting VD. From its headquarters in Hygeia House in Toronto it produced booklets with titles that clearly demonstrated the emphasis on sexual control rather than disease control: "How to Teach Little Children," "Child Management" and "Tell Your Children the Truth" for parents; "The Wonderful Story of Life" for young children; "Healthy Happy Womanhood" for girls over fifteen, "An Open Letter to Young Men" for boys the same age, and "The Relations of Men and Women" for those considering marriage. Its periodical *Social Health* had a circulation of four thousand, including local executives of the Council, other associations, members of parliament and medical health officers. Its chapters were responsible for lecture series in local areas, the Montreal arm managing thirty-seven talks before an estimated 2160 people--usually members of such organizations as the Rotarians, the Board of Trade, the Montreal Women's Club, the Imperial Order of the Daughters of the Empire, the Women's Christian Temperance Union and Big

Sisters--between 1 September 1925 and 1 May 1926. During that same period, the Council sponsored weekly radio talks in Toronto. The Ontario chapter also set up information booths at exhibitions in the cities and larger towns.[127] An exhibit of this type that ran for six weeks in Toronto in 1927 and then went on tour "consisted of wax models, lantern slides, moving pictures, daily health talks, all demonstrating the wrong ways of life and their results, or showing definitely the right and wholesome ways of life."[128] As tame as these programs may sound, they must have had at least some entertainment value. When strapped for money after the federal government cut off all grants in the early 1930s, the Council showed an old silent wartime propaganda film *The End of the Road* to crowds in Toronto and Montreal. In Toronto alone, fifty thousand people attended in two weeks and the Council realized a surprising profit.[129]

There was a real problem with this type of propaganda. Most of the Council's sermons went to the converted. One representative of the Dominion Council of Health condemned the lectures given by the social hygiene people as useless.[130] According to the view that low morals meant probable venereal infection, the people it was really urgent to contact were those who were much more likely to be reading "the rotten literature."[131] Even the converted quit listening by mid-decade. Lectures were no longer well attended. Rather than get out of publicity work, the Council restructured its constitution to allow it to extend its propaganda into more general types of health subjects.[132] The Department took the alternative step of cutting back on the amount of information released, lamenting that "[the] interest which was awakened following the war has subsided and the public is today apathetic if not inimical to venereal disease propaganda of an intensive type."[133] Instead, the instruction of children was to be left to parents[134] and publicity regarding the clinics left to "appreciative patients."[135]

Indeed the clinics were doing useful work. They certainly did more to combat the spread of VD than the prudish non-information peddled by the Department and Council. The unfortunate thing was that although the people who quit attending the lectures probably included very few being served by the clinics and although annually ascending case loads at the clinics demonstrated both need and utilization, federal grants for VD began to dwindle at approximately the same rate as did the crowds at the hygiene lectures. The first cut came in 1924 to apply to the next year. The Dominion Council of Health, certain that the grant could not have been cut had the public been more educated as to its importance, decided to release to the press reports from the Department and the Council on the seriousness of the situation.[136] This attempt to enlist public support was a clear indication that the pressure--so emphatic only five years before--was off.

The number of clinics had grown to fifty-four by the beginning of 1923.[137] Despite curtailment of grants, this increased to over one hundred by the early 1930s.[138] Clinic type of treatment had some advantages. According to the Department, it accustomed the public to the idea that VD was a disease like any other, gave students a chance to study the disease, and gave good care because its success depended on its reputation and because its staff became specialists in the treatment of syphilis and gonorrhea.[139] Unfortunately, clinics needed a large, concentrated population in order to be worthwhile. In outlying areas, drugs were distributed to local doctors free of charge and they were paid a small fee to apply them. This might have been an advantage to the infected in those areas--people who could afford it generally preferred to pay a private physician rather than go to a public clinic for treatment--except for the fact that at least the treatment of syphilis required some expertise. The provinces did try to make sure that doctors getting the free Salvarsan were capable but control was by no means absolute.[140] Alberta's representative to the Dominion Council of Health, W. C. Laidlaw, deplored the ineptitude of some doctors revealed to him in a tour of country districts.

> I saw a good many arms where doctors, who have had very little practice in this work, have attempted to inject salvarsan and I have also seen some arms cut up in an endeavor to strike a vein. It seems to me essential that practitioners should get more education along these lines.[141]

Still, Laidlaw could not agree with the suggestion of another representative that all VD work be moved to hospitals so that more students and general practitioners could observe treatment first-hand.[142] Many patients, he insisted, would not go near a hospital, "especially those who ask the doctor if they can come down at night."[143] The fact of the matter was that fear of detection interfered with the VD program from the start. People worried not only that they would be reported by the doctors[144] or be seen entering hospitals.[145] They were especially terrified of being seen entering a well-publicized clinic, the only purpose of which was VD treatment. Saskatchewan tried to get around this in its smaller centres by placing the clinics in downtown buildings containing other offices. In this way the patient's mission was not so obvious.[146] Even then, most clinics were only open during business hours,[147] making it difficult for the very people they were trying to attract--young working men and women between the ages of nineteen and twenty-five who had the highest rate of incidence and usually insufficient money to seek private care[148]--to attend without gaining permission from a not necessarily understanding employer.

Still patients came--in 1923, at the rate of about one thousand new cases per month.[149] Some came on their own initiative but others attended after having their unsuspected condition revealed to them by routine Wassermann tests the provinces arranged to have done in general, women's, children's and maternity hospitals, at health centres, child welfare and maternity clinics and at day nurseries.[150] Case-finding was also carried out among all inmates of gaols, the class of people--especially those imprisoned for prostitution--considered most likely to spread the disease.[151] In Quebec, sex offenders were examined before sentencing.[152] Case-finding was also practised among suspected female offenders who had not yet been sentenced. In Manitoba, "whenever a girl is taken up for vagrancy by our police, she is examined to see if she is infected."[153] In some provinces, infection alone was reason enough to be sent to prison and kept there until declared non-infectious. Alberta's lady magistrates tried forty-two such cases in 1920, seventy-five in 1921. Proof of infection could mean incarceration in the special VD section of the gaol at Fort Saskatchewan.[154]

If case-finding was an on-going project of VD officials, so was case-holding. Treatment for the venereal diseases, especially that for syphilis, was, although effective by this time, extremely unpleasant. After a few weeks, the specifics would have relieved the most uncomfortable symptoms of the diseases and the painful treatments no longer seemed worth suffering through. Yet, for gonorrhea, actual cure was still up to a year away and for syphilis, as much as three years.[155]

How to get people to carry through with possibly years of weekly, disagreeable treatments became a special problem for the VD program. Counselling convinced some to stay on until cured[156] and threats of publication of their names kept others in line[157] but there was another type of case generally referred to as "those who are spreading the disease."[158] This latter designation seemed to have little to do with one's degree of infectiousness but rather with one's morals, lifestyle and economic class. The clinics did their best within their limits but success in case-holding among cases that did not want to be held was not marked.

> Successful follow-up work has been carried on in varying degrees in the different provinces. No other part of the work of venereal disease control is quite so difficult, for, apart from the question of funds, there is the fact that patients give false names and false addresses, frequently move from place to place and even leave the country, which makes it quite impossible for authorities to trace them. The co-operation of the police is usually sought only in case of delinquents who are known spreaders of venereal disease.[159]

Something had to be done to check these disseminators of VD. General incarceration was considered but soon proved to be impracticable.

> We started out by putting a lot of these "flappers" and men in jails and we filled the jails very soon. Under the Act, I have the power of commitment, but we do not get much result from that. And then we confined them in hospital, but they ran away. That part, again, to my mind, can only be answered by the establishment of detention homes.[160]

Such homes or, more honestly "prison farms" as they were earlier termed,[161] mercifully were never provided. As a result, although several provinces had laws allowing them to lock up so-called delinquents or "spreaders," only one or two went to any lengths to enforce them.[162] The alternative seemed to be stricter follow-up work, especially of "some of these loose characters among the women [who] are great sources of spreading the disease. A lot of young girls in their late teens who are not under supervision are frequently a source of infection."[163] But the truth was that, in spite of punitive legislation, spreaders of social disease were regarded in the long run not as criminals but as victims of a general breakdown in Canadian social life. Post-World War I Canada was a place fraught with numerous dangers for the unwary, usually young, person. It was a country where prostitution was supposedly rife and considered responsible for seventy percent of all VD,[164] especially among young men under the influence of alcohol.[165] Young women were also in danger as they were "leaving the protective atmosphere of the home and entering industrial life."[166] Once out of the family home and into boarding-houses, "dreary places at best," young people sought companionship in streets, public parks and, worst of all, automobiles. In fact, "the opportunities afforded by the automobile" were seen as eating into the brothel trade and in Canada, as elsewhere, "houses of prostitution have diminished in number and . . . the motor car is taking their place."[167]

Obviously there had to exist a focus of infection wherefrom this pool of essentially decent, though temporarily misguided, young people received outside infection. This role was played by not only the prostitutes[168] (mentally defective or no), but also the foreign[169] and the poor.[170] Such people were not deemed likely to have much social conscience. Since they were assumed not to have the good of the Canadian population as a whole at heart, that population must protect itself from infection by them. It is for this reason that, despite the clinics and the free diagnosis and the other trappings of medical care, the VD program was permeated much less by an aura of disease control than one of social control. Criminals were incapable of redemption--for them the incarceration and compulsory treatment laws existed. Responsible citizens could look after themselves or if infected "innocently" would pointedly seek and continue care. But a grey area existed between these two extremes of society. Peopled largely by children and innocent, though possibly slightly wayward, youth, this group had to be protected and disciplined. Positive tactics tried were stress on recreational facilities to remove harmful influences and supervision of dance halls, pool rooms, movies and other places of public amusement.[171] More repressive tactics were raising the age of consent, penalizing unmarried couples who registered in hotels as man and wife, and contemplated penalties for owners of motor vehicles who used or allowed others to use their vehicles for immoral purposes.[172]

The most demanded social measure was, however, a compulsory VD examination to be undergone at the time of application for a marriage license. This would have three effects. First, it would guarantee "clean cradle immigration,"[173] by which was meant healthy Canadian births without taint of congenital syphilis or gonorrhea complications such as ophthalmia neonatorum. Second, it would prevent infection by newly-taken spouses, who may or may not be really decent people but were nonetheless diseased.[174] Third, it was felt that this would stop the unfit from marrying and producing tainted children. This last category consisted not simply of people with a disease but of the sort of people likely to be diseased--not only the infected but the defective.[175] In Canada various groups called for legislation along this line. In Alberta alone, the Anglican Diocese of Edmonton, the United Farmers of Alberta, the United Farm Women of Alberta and the Alberta Social Hygiene

Council all petitioned the provincial government.[176] However, while the Deputy Minister of Public Health was in favor of all fiancés taking an oath swearing that they had never been infected with VD or, if so, had been declared free of infection by a medical examiner within the last three months, he did not consider stronger measures possible.[177] The Department of Health also felt that the desirability of compulsory examination was debatable.[178] Concerned organizations were forced to fall back on the old mainstay of public instruction. The Canadian Social Hygiene Council established a committee made up of clergy to work "on matters concerning marriage, the education of people for marriage, and measures to conserve the health of people entering the married state."[179] It is questionable whether this type of edification touched or even reached the people it was meant for.

It would be rash to write off the federal-provincial venereal disease campaign as a failed reform. The clinics cared for thousands of sick Canadians. During the fiscal year ending 31 March 1929, the last year during which Health had stood alone, provincial clinics treated 7666 persons for syphilis, 10,938 for gonorrhea and 369 for chancroid, one of the less publicized of the dozen or so venereal diseases.[180] The problem was that expectations had been too high. While VD was being treated, it was not being eradicated. The reform ideals arising from World War I had all been irrepressibly military in tone--social problems, among them the social diseases, were to be beaten, defeated, wiped out. Simple treatment with an eye to possible control seemed too little result for the effort expended. The Department of Health had simply not been prepared for a long-term battle, certainly not one of attrition. The provinces demanded that the

$200,000 VD grant from the Dominion be provided for three years. That much they got. In 1922, they asked for another three-year guarantee.[181] By the end of 1923, Amyot informed them that they would have to make a pointed representation.[182] It was generally acknowledged that the clinics did good work, especially against syphilis[183] but there was something unsavory about success at just treatment. One concerned Canadian described clinics of this type as

> "spots" in different parts of the city where men who have unfortunately had their penis in suspicious surroundings may have it properly laundered with permanganate or other solution and thus avoid the results of their social crime.[184]

This attitude lingered. The Department lamented in mid-decade that, clinics and education aside, the campaign seemed to be having little success in "preventing immoral relationships."[185] In short, social disease was seen as a disease of Canadian society, not of Canadian bodies. Curing the bodies was not curing the society. Perhaps adequate treatment for VD was counterproductive--it removed some of the fear of punishment from fornication. This attitude was certainly alive thirty years later when penicillin arrived on the scene, making treatment almost entirely effective, short-term and painless. One Canadian cleric warned:

> In the campaign against venereal diseases there is a grave danger that we shall regard the problem almost solely as a medical problem and not also in its sociological and moral implications.[186]

Successful treatment by the clinics, then, simply did not, by definition, equal successful venereal disease control. Loath to throw good money after bad, and despite pleas from the Dominion Council of Health, the Canadian Social Hygiene Council, the Canadian Public Health Association, the provinces and members of parliament,[187] the federal government announced in early 1924 that it was cutting the grant by twenty-five percent.[188] The Dominion Council of Health launched an appeal on the grounds that VD was "by far the most serious public health question to be found in Canada."[189] The fifty thousand dollars was not restored. The next year, the grant was to be cut to one hundred thousand dollars but stayed at $125,000. Amyot warned the provinces that they must prepare for its imminent disappearance and should educate patients now to the eventuality of having to bear full cost of treatment themselves.[190] In 1927, the grant was reduced to one half the original and remained at $100,000 until cut entirely in 1932.[191] As a last hurrah the Department had arranged a series of conferences in 1931[192] but VD control was a dead letter. Not only the grant would disappear during the Depression but also the division--in 1934. The spawn of one war, VD control would have to wait for another for rebirth.

Narcotics control and venereal disease control were the two most emphasized innovations of the Department of Health. The campaigns against each had certain parallels. Victims of both of these social problems were divided into respectable sufferers and unrespectable, even criminal, sufferers. This moralizing made it difficult to treat drug addiction and venereal disease as bodily disorders, pure and simple, to which the best medical science could be applied to good effect. They were seen instead as symptoms of a general disintegration of society and it was this social disease at which preventive measures were aimed. Such measures were doomed to ineffectiveness. It was not enough to say to Canadians: do not become addicted, do not become infected, do live bourgeois lives. Threats of incarceration were not enough to keep some people from finding solace in drugs and most from finding solace in sex.

Flummoxed by lack of success at social control of the sort considered ideal, health officials allowed both programs to slide into punishment. Although such punitive and repressive measures may have had some small success in preventing some people from contracting these diseases, they could not really be termed health policies. They did not actively promote physical well-being. At most, they prevented illness in somewhat the same manner as the old quarantine-type divisions. The Department had been unable to escape its traditional bonds. Because parts of the narcotics and venereal disease control programs could be dealt with within those bonds, they enjoyed a degree of success. The remaining reform responsibilities of the Department--child welfare, housing, sanitation and hospitalization--were less amenable to quarantine solutions and would fare less well.

NOTES

[1] Commons, *Debates*, 1922, p. 87.

[2] *Ibid.*

[3] Martin J. Maloney, *ibid.*, 1928, p. 3782.

[4] Reginald Whitaker, *Drugs and the Law. The Canadian Scene* (Toronto: Methuen, 1969), pp. 40-1.

[5] These and other related pieces of correspondence are to be found in PAC, RG 29, vol. 602 (file 325-1-3).

[6] Spelling his. *Ibid.*, Clark to Murphy, 17 December 1919.

[7] Emily F. Murphy, *The Black Candle* (Toronto: Coles Publishing Co., 1973). Facsimile of 1922 edition published by Thomas Allen, Toronto.

[8] PAC, RG 29, vol. 551 (file 320-6-5) to F. W. Cowan, 11 January 1923.

[9] Commas all his. *Ibid.*, Cowan to Donald, 25 January 1923.

[10] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 3.

[11] *Report, Health, 1920*, p. 16.

[12] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 9.

[13] *Ibid.*, pp. 9-10. *Report, Health, 1921*, pp. 15-7. See PAC, RG 29, vols. 234 and 235 for some individual cases.

[14] PAC, RG 29, vol. 551 (file 320-6-5) Dr. C. F. Smith of St. Mary's, Ontario to Amyot, 22 December 1922, asking him to confirm the *Globe* article.

[15] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 2.

[16] *Ibid.*, 7th meeting, 28-30 November 1922, Notes of Dr. J.W.S. McCullough.

[17] Editorial, Calgary *Herald*, 16 July 1908. Cited in Terry L. Chapman, "'The Drug Problem' in Western Canada, 1900-1920" (unpublished M.A. thesis, University of Calgary, 1976), p. 57.

[18] PAC, RG 29, vol. 236 (file 324-1-2, part 1) Dr. B. J. McConnell, Secretary of the Manitoba Narcotic Act, to Cowan, 18 March 1920.

[19] Commons, *Debates*, 1920, p. 1754. It was hoped by Amyot that doctors would switch to substitutes for the restricted narcotic drugs,

especially for cocaine. He was not optimistic. PAC, DCH Minutes, 9th meeting, 11-13 December 1923, p. 4.

[20] PAC, RG 29, vol. 236 (file 324-1-2, part 1) Cowan to McConnell, 9 March 1920. McConnell, himself, was under RCMP investigation when he died unexpectedly in February 1923.

[21] *Ibid.*, telegram McConnell to Cowan, 31 March 1920.

[22] *Ibid.*, vol. 602 (file 325-2-5) and vol. 603 (file 325-2-15, parts 1, 2, 3).

[23] Commons, *Debates*, 1920, p. 957.

[24] Peter McGibbon, *ibid.*, p. 1748.

[25] Jacques Bureau, *ibid.*, p. 1634.

[26] Dr. Mathew R. Blake assured the House that doctors would not abuse their position. *Ibid.*, p. 1640. On 9 June 1928, McGibbon was joined in the House of Commons by two other members, Dr. John P. Howden and Dr. Robert K. Anderson, in a long defence of the medical profession in this matter. Their argument was that it was not dignified for the medical profession to be checked up on in this manner. *Ibid.*, 1928, pp. 4052-7.

[27] PAC, RG 29, vol. 236 (file 324-1-2, part 1) 28 January 1920.

[28] *Ibid.*, vol. 602 (file 325-2-4).

[29] Whitaker, pp. 41-2.

[30] PAC, DCH Minutes, 11th meeting, 15-17 December 1924, pp. 1-2.

[31] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 10.

[32] *Ibid.*, vol. 611 (file 30-1-4) Account of War Activities (of World War II) . . ., p. 27.

[33] Wodehouse and Heagerty, p. 156.

[34] *Ibid.*, pp. 157-8.

[35] *Report, Health, 1922*, pp. 32-5.

[36] *Ibid., 1923*, pp. 34-41.

[37] *Ibid., 1924*, pp. 31-7.

[38] *Ibid., 1925*, pp. 24-7.

[39] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, pp. 3-4.

[40] H. S. Béland, Commons, *Debates*, 1923, p. 698. The rest were 13 doctors, 11 druggists, 1 veterinary surgeon and 129 dealers other than Chinese.

[41] PAC, RG 29, vol. 551 (file 320-6-5) to Cowan, 5 January 1923.

[42] *Ibid.*, vol. 600 (file 324-2-8, parts 1 and 2).

[43] Murphy, facing p. 30, captioned "When she acquires the habit, she does not know what lies before her; later she does not care;" and facing p. 46, captioned "Once a woman has started on the trail of the poppy, the sledding is very easy and downgrade all the way."

[44] *Ibid.*, p. 17.

[45] *Report, PNH, 1931*, pp. 78-96.

[46] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 11.

[47] *Report, Health, 1929*, pp. 85-6.

[48] *Ibid., 1926*, p. 25.

[49] *Ibid., 1927*, p. 12.

[50] *Report, PNH, 1929*, p. 86.

[51] PAC, RG 29, vol. 539 (file 320-1-11) C.H.L. Sharman (head of Division beginning in early 1928) to Archibald Blackie, Winnipeg, 28 August 1928.

[52] *Ibid.*, vol. 551 (file 320-6-5).

[53] *Report, Health, 1924*, p. 36.

[54] Béland, Commons, *Debates*, 1923, p. 698.

[55] McGibbon, Commons, *Debates*, 1920, p. 1754.

[56] *Report, PNH, 1930*, p. 70.

[57] PAC, RG 29, vol. 236 (file 324-1-2, part 1) McConnell to Cowan, 18 March 1920.

[58] *Report, PNH, 1930*, p. 69. Another theory was that some people turned to narcotics because of the laws prohibiting alcohol. PAC, RG 29, vol. 551 (file 320-6-5) Smith to Amyot, 22 December 1922.

[59] PAC, RG 29, vol. 236 (file 324-1-2, part 1). See replies to circular letter from the Opium and Narcotic Drugs Branch asking each province for its relevant laws and statutes, 28 January 1920.

[60] *Ibid.*, vol. 551 (file 320-6-5) Sharman to Dr. R. C. Hamilton of Ponoka Mental Hospital, Alberta, 19 December 1935.

[61] *Report, Health, 1926*, p. 25.

[62] PAC, DCH Minutes, 7th meeting, 28-30 November 1922, Notes of J.W.S. McCullough.

[63] PAC, RG 29, vol. 236 (file 324-1-2, part 1).

[64] *Ibid.* (file 324-1-2, part 2) G. H. Agnew of Canadian Medical Association's Department of Hospital Service to Amyot, 31 December 1928.

[65] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, pp. 21-2.

[66] Ian H. Clarke, "Public provisions for the mentally ill in Alberta, 1907-1936" (unpublished M.A. thesis, University of Calgary, 1973), pp. 69-70.

[67] PAC, RG 29, vol. 236 (file 324-1-2, part 2) Agnew to Amyot, 31 December 1928.

[68] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, pp. 32-5.

[69] PAC, RG 29, vol. 236 (file 324-1-2, part 1) McConnell to Cowan, 7 April 1920. DCH Minutes, 19th meeting, 18-20 November 1929, pp. 4-6.

[70] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, pp. 21-2.

[71] Although one doctor was using bleeding as late as 1922. PAC, RG 29, vol. 236 (file 324-1-2, part 1) Dr. F. N. Starr of Toronto to Amyot, 8 December 1922. He reported good results in one case but disappointment in another wherein he had to stop bleeding the woman involved due to anaemia.

[72] *Ibid.*, vol. 557 (file 321-4-2) Report of Sharman, 15 June 1927.

[73] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, pp. 55-6; 17th meeting, 19-21 June 1928, pp. 3-4.

[74] PAC, RG 29, vol. 236 (file 324-1-2, part 1) Cowan to McConnell, 13 April 1920.

[75] *Ibid.*, vol. 551 (file 320-6-5) Sharman to Hamilton, 19 December 1935.

[76] Amyot, PAC, DCH Minutes, 17th meeting, 19-21 June 1928, pp. 3-4.

[77] *Ibid.*, 18th meeting, 4-6 December 1928, p. 4.

[78] PAC, RG 29, vol. 236 (file 324-1-2, part 1) Cowan to all provinces, 12 December 1922.

[79] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, p. 4.

[80] PAC, RG 29, vol. 236 (file 324-1-2, part 1) Amyot to T. C. Routley, 20 January 1930.

[81] *Report, PNH, 1930*, p. 71.

[82] *Report, Health, 1923*, p. 22.

[83] In 1919, a Miss Haines, an administrator of the Patriotic Fund which was used to subsidize emergency medical care for certain classes of immigrants, informed the Department of Immigration and Colonization that her agency would no longer be responsible for expenses connected with the venereal diseases. PAC, RG 29, vol. 287 (file 402-7-2) Pagé, Acting Dominion Immigration Agent to W. R. Little, Commissioner of Immigration, 20 August 1919. Pagé wanted to know if this Department would now pay city hospitals for costs incurred in treatment of such cases. See also Chapter 1 above regarding the return of infected soldiers.

[84] ". . . the admittance of mental defectives at the ports of entry increases illegitimacy and venereal diseases." Manion, Commons, *Debates*, 1919, p. 1181. Mental defectives supposedly had an abnormally high sex drive as well as a lack of discrimination when it came to sex partners. As late as the Second World War, a senior official in the Department of Pensions and National Health stated that ". . . the physically attractive mentally defective woman may become a disseminator of the venereal diseases." PAC, RG 29, vol. 501 (file 311-V3-34, part 2) Heagerty to R. A. Gibson, Deputy Commissioner of the North-West Territories, 25 November 1941.

[85] See Chapter 2 above.

[86] PAC, DCH Minutes, 6th meeting, 13-15 June 1922, proposed agenda and p. 2 of memorandum of J.W.S. McCullough.

[87] Jeffs, p. 284.

[88] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 19.

[89] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 40-1. RG 29, vol. 501 (file 311-V3-34, part 2) Ordinance signed by W. W. Corry, Commissioner of North-West Territories, 12 January 1921.

[90] Usually brothels. Canada, *Report, Health, 1923*, p. 27.

[91] Dr. William F. Roberts, Minister of Health for New Brunswick wanted ". . . a prison farm as a place where we would be able to place our cases of V.D. where we think it necessary to detain them . . ." PAC, DCH Minutes, 3rd meeting, 25-26 October 1920, p. 18.

[92] R. H. Butts queried whether it was worthwhile to pass laws regarding the control of venereal diseases and whether it would "not be better to clear these people out altogether?" Commons, *Debates*, 1919, pp. 1171-2.

[93] Gordon Bates, "Venereal Disease Control in Canada," *CPHJ*, XXV (February 1934), 60.

[94] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, p. 5.

[95] "Federal and Provincial Responsibilities in Public Health," *CPHJ*, XXV (October 1934), 498. "Had not the Dominion Government made a grant to the provinces, the work of venereal disease control would not have been undertaken by the provinces, and the amount of uncured venereal disease would have been enormous." PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 20.

[96] Bates, "Venereal Disease Control in Canada," p. 60.

[97] Alberta, *Report of the Task Force to study the problems of Venereal Disease in the Province of Alberta* (Edmonton: Alberta Social Services and Community Health, March 1976), Appendix 1.

[98] J. T. Phair, "Public Health in Ontario," in Defries, *The Development of Public Health in Canada*, pp. 72-3.

[99] PAC, DCH Minutes, 3rd meeting, 25-26 October 1920, p. 5. The major drug used, Salvarsan, had come from Germany before the war cut off supplies. Canadian laboratories then took over production, licensed under the War Measures Act. At least the Ontario government considered producing some for its own use but in the end left it to the private enterprise of a doctor's son. Two companies had a monopoly on Canadian supplies of Salvarsan by the end of the war, and were accused of forcing up the price. As an antidote, provincial representatives of the Dominion Council of Health wanted licenses to produce their own supplies and a promise that import restrictions and duties would be lifted to reduce the price. *Ibid.*, 1st meeting, 7-9 October 1919, p. 3; 3rd meeting, 25-26 October 1920, p. 23.

[100] *Ibid.*, 5th meeting, 19-21 October 1921, summary of matters discussed.

[101] *Report, Health, 1920*, p. 19.

[102] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, pp. 1-2. For files on general administration of the provincial grants, see PAC, RG 29, vols. 362 to 370A.

[103] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 17.

[104] *Ibid.*, p. 18.

[105] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, p. 34.

[106] *Ibid.*, 1st meeting, 7-9 October 1919, p. 1.

[107] *Ibid.*, 2nd meeting, 17-19 May 1920, p. 34.

[108] *Ibid.*, pp. 34-8; 1st meeting, 7-9 October 1919, pp. 1-2.

[109] See, for example, Alberta's *Act for the Prevention of Venereal Disease* (1918). Reprinted in Alberta, *Report of the Task Force to study . . .*, Appendix 1.

[110] Gordon Bates, "The Venereal Disease Problem in Canada," *CPHJ*, XXVIII (October 1937), 485-6.

[111] PAC, MG 27 II D13, vol. 18; J. B. Allen, Officer of the Privy Council to Rowell, 18 June 1918. *Report, Health, 1923*, p. 27.

[112] Birch, p. 18.

[113] See Chapter 1 above. See also Janice P. Dickin McGinnis, "From Salvarsan to Penicillin: Venereal Disease Control in Canada, 1919-1945" (unpublished paper given before the annual meetings of the Canadian Historical Association and the Canadian Society for the History of Medicine, 3 June 1979, at Saskatoon, Sask.), pp. 2-4 and 8-10.

[114] J. Castell Hopkins, *The Canadian Annual Review of Public Affairs, 1919* (Toronto: The Canadian Annual Review, Ltd., 1920), p. 618.

[115] "Innocent" contraction of a venereal disease could come in two ways. The first was by contact with an inanimate object, including dishes, table cutlery, towels, pipes, etc., contaminated by an infected person. See PAC, MG 28 I 25, vol. 67, Nova Scotia, Department of Public Health, *The Venereal Diseases* (May 1917), p. 2. This pamphlet was drawn up at the request of the National Council of Women. The chances of VD being picked up in this way are almost nil. The second means of contraction was through infection by a wayward spouse, a subject of particular concern to women reformers. A letter from Mrs. S. Davies of the Manse, Smith Falls, Ontario to Heagerty [no date but certainly 1927, likely mid-October] gives a brief synopsis of social collapse considered to accompany such innocent infection:

> I should appreciate your forwarding me some information on the following questions. What percentage of men contract venereal diseases from frequenting houses of prostitution? What percentage of wives contract it from their husbands? What percentage of wives go insane or commit suicide who have immoral husbands? To what extent do children of immoral parents inherit immorality? Would girls with an immoral father but a moral mother, who will endeavor to train her daughter to be moral be inclined to be immoral?

Heagerty replied, 25 October 1927, that such information was simply not available but that in his opinion except for certain "moral defectives who have inherited their immoral tendencies," good up-bringing was the key. PAC, RG 29, vol. 212 (file 311-V3-5, part 1).

[116] "Was not one of the chief reasons for establishing Government venereal disease clinics to overcome the evil arising out of self medication and the treatment by quacks of these diseases?" *Ibid.*, F. S. Parney of the Department of Pensions and National Health to Dr. A. L. MacKay, Director of Ontario Preventable Disease Division, 30 October 1934.

[117] *Report, PNH, 1931*, p. 131.

[118] "Parents, mothers, particularly, and educators fear that lectures on the subject of venereal disease to boys of fourteen may be productive of more harm than good." *Report, Health, 1923*, pp. 25-6.

[119] In July 1922, the Department ordered two films on VD from the American Social Hygiene Association. The films were ideal except for one thing. "There is very decided objection on the part of the medical profession to the showing of these films to the public, on account of the fact that 'treatment' of these diseases is included in the film." Heagerty to Secretary of the ASHA, 26 July 1922. The Association replied, 31 July 1922, that it would cut out the offending frames before sending the films. PAC, RG 29, vol. 215 (file 311-V3-18, part 1).

[120] *Ibid.*, vol. 212 (file 311-V3-5, part 1) Heagerty to Mrs. C. Geddes of Roland, Manitoba, 26 May 1926. He refuses to send her information for "a friend" who fears she has been infected by her husband. "By giving her literature such as we have here she, undoubtedly, will become hypochondriacal and a burden to herself."

[121] *Report, Health, 1923*, p. 24.

[122] *Ibid.*, pp. 24-5. For titles see *ibid.*, *1925*, p. 27. PAC, DCH Minutes, 5th meeting, 19-21 October 1921, p. 3.

[123] *Report, Health, 1924*, p. 27.

[124] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 1.

[125] PAC, RG 29, vol. 493 (file 311-V3-29, part 1) Series of handwritten letters sent back to the Department by Heagerty, describing life on the lecture circuit.

[126] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, pp. 13-4. Pankhurst also gave lectures in several other provinces that same year. Hopkins, *1923*, p. 490.

[127] PAA, Premiers' Papers, file #0433, "Canadian Hygiene Council, Annual Meeting, 1926," 9 pp.

[128] Hopkins, *1923*, p. 477.

[129] Bates, "Venereal Disease Control in Canada," p. 66.

[130] Dr. Gordon Bell of Manitoba, PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 19.

[131] PAC, RG 29, vol. 493 (file 311-V3-29, part 1) Heagerty to Amyot, quoting Bates, 29 January 1923. Henri Bourassa made the following observation on the risk to health of reading risqué tabloids from the United States: "Not later than this week one of the most respectable and best informed persons in the city of Ottawa told me of girls and

boys of the public schools in another city being carried to the hospitals with venereal disease and who were found to have in their beds, for solace during illness, some of these very publications which enter this country under the regime of freedom which is recommended to us as the proper thing." Commons, *Debates*, 1928, p. 3579.

[132] PAA, Premiers' Papers, file #0433, "Canadian Social Hygiene Council, Annual Meeting, 1926," p. 8. *Report, Health, 1927*, p. 65.

[133] *Report, Health, 1926*, p. 24.

[134] *Ibid., 1925*, p. 22.

[135] *Report, PNH, 1931*, p. 131.

[136] PAC, DCH Minutes, 11th meeting, 15-17 December 1924, pp. 37-8.

[137] Nova Scotia, 5; New Brunswick, 8; Quebec, 10; Ontario, 15; Manitoba, 4; Saskatchewan, 6; Alberta, 4; and British Columbia, 2. *Report, Health, 1923*, p. 23.

[138] Bates, "Venereal Disease Control in Canada," p. 60.

[139] *Report, Health, 1923*, p. 23. For files on general administration of the clinics, see PAC, RG 29, vols. 497, 498 and 502-505.

[140] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 18.

[141] *Ibid.*, 9th meeting, 11-13 December 1923, p. 17.

[142] P. H. McCalman of Manitoba, *ibid.*, p. 16.

[143] *Ibid.*, p. 17.

[144] *Ibid.*, p. 18.

[145] *Ibid.*, 3rd meeting, 25-26 October 1920, p. 16.

[146] *Ibid.*, 9th meeting, 11-13 December 1923, p. 21.

[147] *Report, Health, 1923*, p. 23.

[148] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 18.

[149] *Report, Health, 1923*, p. 23.

[150] *Ibid., 1925*, p. 21.

[151] *Ibid.*, pp. 21-3; *ibid., 1923*, p. 24.

[152] Elzéar Pelletier, "Public Health in Quebec," in Defries, *The Development of Public Health in Canada*, pp. 17-8.

[153] McCalman, PAC, DCH Minutes, 9th meeting, 11-13 December 1923, p. 15. He cites no similar policy towards arrested males although "[we] have occasionally a man who ceases to come for treatment and he is looked up."

[154] Alberta, *Annual Report of the Department of Public Health, 1920*, p. 22 and *ibid., 1921*, p. 60.

[155] For a description of the diseases and their remedies see Dickin McGinnis, "From Salvarsan to Penicillin," pp. 4-8, 10-6.

[156] *Report, Health, 1923*, pp. 26-7.

[157] Bates, "Venereal Disease Control in Canada," p. 62.

[158] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 19.

[159] *Report, Health, 1925*, p. 23.

[160] H. E. Young of British Columbia, PAC, DCH Minutes, 9th meeting, 11-13 December 1923, p. 14.

[161] *Ibid.*, 3rd meeting, 25-26 October 1920, p. 18.

[162] *Report, Health, 1923*, p. 27.

[163] Dr. MacLean, Deputy Minister of Health for British Columbia, PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 19.

[164] "Commercialized prostitution" accounted for 35%, "clandestine prostitution" for 36%. *Report, Health, 1923*, p. 28.

[165] "Disease contracted under the influence of alcohol amounts to 25 percent of the whole." *Ibid.*

[166] *Ibid., 1928*, p. 67.

[167] *Ibid.* Late marriages were also seen as a concomitant factor.

[168] Mackenzie King, who frequented prostitutes, had himself checked for evidence of VD in 1896. C. P. Stacey, *A Very Double Life. The Private World of Mackenzie King* (Toronto: Macmillan, 1976), p. 46.

[169] Robert K. Anderson claimed that sixty percent of those attending VD clinics were "members of our foreign population." Commons, *Debates*, 1929, p. 2618.

[170] Described as a "typical case of family syphilis" was a man in Brantford on city relief, his wife and seven living children. Of these, the eldest was partially deaf and blind; the next two, deaf and dumb; the fourth crippled by long bone syphilitic infection; the fifth, mentally defective; the sixth, idiotic; and the eighteen month old baby, syphilitic. One or two other children had died earlier. "This case is

a good example of the cost of Venereal Diseases to the country." PAA, Premiers' Papers, file #0433, "Venereal Disease Statistics" [1924?], p. 2. This thinking is based on hysteria more than facts. Miscarriage and stillbirth are the characteristic products of venereal disease, not mental defectiveness and idiocy. Such a large family would be unlikely, and had the woman been suffering from syphilis at the time of the birth of the first child, chances are that by the birth of the later ones she would be much less infectious and such children would have been normal. See Frederick F. Cartwright, *Disease and History* (New York: New American Library, 1972), pp. 60-1.

[171] *Report, Health, 1924*, pp. 27-8.

[172] *Ibid., 1923*, p. 27.

[173] PAA, Premiers' Papers, file #0433, "Some Considerations on Venereal Disease," mimeograph of editorial from *CPHJ* [1924?], p. 3.

[174] There was some question as to whether the pre-marital VD exam should apply to women as well as men. When similar legislation was being considered, and sometimes passed, by some of the United States, the Russell Sage Foundation, a social service organization, stated the case against equal examination for women: "The many critics who assert that the law should apply to women as well as men fail to recognize the much more frequent infection among unmarried men than among unmarried women, and also fail to realize that in the present state of public opinion it is practically impossible to subject women to compulsory examination in order to establish their freedom from Venereal infection." PAA, Premiers' Papers, file #169B, Memo from M. R. Bow, Deputy Minister of Public Health to Hon. George Hoadley, Minister of Health, 10 October 1930, p. 3.

[175] Mrs. C. E. Flett, one of the women's representatives on the DCH, bewailed the prospects of "children at the mercy of parents cometimes [sic] immature, diseased, immoral or so ignorant that they are not fit to be parents." PAC, DCH Minutes, 9th meeting, 11-13 December 1923, p. 46.

[176] PAA, Premiers' Papers, files #168C, 169B, 169C and 0433.

[177] *Ibid.*, file #169B, Memo from Bow to Hoadley, 10 October 1930, p. 4. One problem with such an exam was that the Wassermann was not one hundred percent reliable and a false positive could have disastrous effects on a person's private life.

[178] *Report, Health, 1925*, p. 23.

[179] PAA, Premiers' Papers, file #0433, Report of the Canadian Social Hygiene Council, Annual Meeting, 1926, p. 7.

[180] *Report, PNH, 1929*, p. 124.

[181] PAC, DCH Minutes, 7th meeting, 28-30 December 1922, pp. 2-3.

[182] *Ibid.*, 9th meeting, 11-13 December 1923, p. 9.

[183] *Ibid.*, 6th meeting, 13-15 June 1922, p. 3. *Report, Health, 1926*, p. 25; *ibid., 1928*, p. 68.

[184] Letter (signature omitted) to Grant Fleming, assistant medical officer, University of Toronto, 26 August 1922. PAC, RG 29, vol. 39 (file 35-2-5, part 1) quoted in Suzann Buckley, "The Impact of World War I upon Canadian Public Health Reform" (unpublished manuscript given before the Annual Meeting of the Canadian Association of American Historians, Conference on the City, Hamilton, October 1977), p. 14.

[185] *Report, Health, 1927*, p. 65.

[186] C. E. Silcox, "The Moral and Social Factors in Venereal-Disease Control," *CPHJ*, XXXVI (December 1945), 472.

[187] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, Resolution 2. PAA, Premiers' Papers, file #0433, "Venereal Disease Statistics," p. 3. *Ibid.*, "The Venereal Diseases Grant" and "Some Considerations on Venereal Diseases," both reprints of editorials from *CPHJ* [1924?]. *Ibid.*, "Some Facts concerning Venereal Diseases and their control in Canada," p. 1. J. S. Woodsworth and S. F. Tolmie, Commons, *Debates*, 1925, pp. 5028-9.

[188] PAC, DCH Minutes, 10th meeting, 24-26 June 1924, n.p.

[189] *Ibid.*, n.p.

[190] *Ibid.*, 12th meeting, 11-13 June 1925, pp. 18-20.

[191] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 18.

[192] Bates, "Venereal Disease Control in Canada," p. 63.

> There can be only one effect of this amalgamation, and that is the uniting of the soldiers' department to a department that is a corpse, nothing more or less. If the Department of Health during its seven or eight years of existence had in any respect led us to believe that it ever could do anything I would not object so much, but I have been studying the working of that department now for some years and I cannot find anything it has done that was not equally well done before.
> --Peter McGibbon in the House of Commons, 13 April 1928.

Chapter Four

THE PROMOTION OF HEALTH

INFORMATION AND PUBLICITY, 1919-1929

At the end of the Second World War, a Canadian health writer outlined three stages in the history of the fight for public health. From 1840 to 1890, stress had been put by western civilization on sanitation. With the acceptance of the germ theory of disease, attention shifted to bacteriology, 1890 to 1910. From 1910 on, public health hopes were laid at the door of health education.[1] Education was expected to move people and populations to apply the technology and knowledge available. In this way, the standard of public health would be raised through individual, sometimes collective, action. No coercion would be involved: no patient forced to take treatment; no doctor forced to give it; no jurisdiction pressured by higher powers to provide facilities. Once possibilities for better health were fully understood, they would be applied, the only motivation needed being supplied by good common sense. Canadian health authorities, like many of their contemporaries, were overweening in their faith in the power of education. Information and publicity, almost singlehandedly, were expected to shoulder the responsibilities of the federal Department of Health in the fields of child and maternal welfare, housing, hospitalization and public health engineering. In addition to releasing information, the Department stockpiled information for the use of certain people. Much of the material gathered was modish and moralistic but some of the literature contained information of real value. The problem was that, valuable or no, Canadians were frequently not in a position to apply such knowledge. Belief in the curative powers of health education failed to take into account the fact that many people could not use the proffered knowledge for lack of time, money, personnel or facilities. The Canadian Department of Health would fail to raise the standard of health through information and publicity but not for lack of trying. It released the best propaganda it could gather. But it had no power and--more importantly--no money to force its application. Supposedly, it was the health professions and the provinces who were to employ all available medical knowledge but they also lacked the power and the money. The inability of Canada to provide, through these channels, an adequate standard of health for its population was obvious to some in the 1920s. The Depression of the 1930s would make it drearily apparent to all.

One of the reforms pushed for hardest and longest during the pre-World War I era was an attack on Canada's high maternal and infant mortality rate. Deaths of mothers and children were seen as forestalling one of Canada's chief aims--as one official put it, the creation of "a strong and healthy race."[2] Provinces[3] and volunteer organizations[4] made sporadic efforts to provide at least natal and hopefully also some pre- and post-natal care for mothers and their children. The federal government promised to join battle through the organization of a relevant division in the new Department of Health.[5] The head of the new Division of Child Welfare was appointed 10 April 1920.[6] She was Dr. Helen MacMurchy, a woman who had previously worked for the Ontario government in this field, preparing a report on infant mortality for that body in 1910.[7] The results of that investigation had clearly shown that deaths were tied to economic circumstances. MacMurchy's reaction to the information she had turned up was not a demand for change in these circumstances through government action but a call for amelioration through action of the individual herself.[8] Women were to be given instruction to help them fight off the dangers threatening them and their children. This same approach was applied by MacMurchy to the federal Division. Attention was centred upon co-ordinating provincial and volunteer child and maternal welfare facilities and upon educating pregnant women to seek medical help. Unfortunately, the co-ordination of pitifully few facilities and the education of women who had no one and no money available to satisfy their recognized needs was not enough. The Division of Child Welfare had no demonstrable effect on Canada's infant and maternal mortality rate. Neither did it manage any great propaganda victories. The esteem in which the campaign was held was neatly summed up during the debate on the amalgamation of the Departments of Health and of Soldiers' Civil Re-establishment in 1928. One proposed title for the new joint department was National Health and Soldiers' Welfare. Arthur E. Ross, the member for Kingston City, dismissed this suggestion contemptuously: "That smacks too much of the child welfare movement, and suggests that it is just about of the same importance."[9] Canada's remaining pensioned soldiers were immeasurably more important than thousands of women and children dead or threatened by death. Public health propaganda had not managed even to convince many people of the seriousness of the problem, let alone to bring about positive reform.

The Dominion Council of Health certainly took the matter seriously enough when it discussed "Conservation of Child Life" at its first meeting in October 1919. Attention was directed at the threats tuberculosis and syphilis presented to the reproduction and health of children; the necessity of good living conditions and rest, especially in the weeks just before and after delivery; the advantages of breast over bottle feeding in imparting immunities to the infant and protecting it from unclean milk supplies; and the dangers of patent foods and soothing syrups. The last item was expected to be cleared up shortly by the new Food and Drugs and Proprietary or Patent Medicine Acts,[10] tuberculosis had definitely been relegated to the provinces and syphilis was supposedly being taken care of by the Division of Venereal Disease Control. Jurisdiction over clean milk would be murky for some years. In 1921, the Council referred the matter of diseased herds to the federal Department of Agriculture[11] and the next year all Dominion regulations regarding milk were wiped out to leave the provinces free to take any necessary action.[12] But by 1926, the Council was still lamenting Canada's unclean milk supply and suggesting the passing of laws for the regular inspection of dairies.[13] The DCH neatly sidestepped the issue anyway by endorsing only breast-feeding on the grounds that:

> The human animal is a mammal. . . . The milk of every mammal is modified to meet the needs of its young. Cows [sic] milk was not intended for the human body.[14]

Good living conditions would supposedly be taken on by the new division of housing. That left Child Welfare with the job of making sure women were healthy and rested when it came time to deliver, were attended to properly at childbirth, and were aware of how to care for their new offspring.

Good health during pregnancy is deeply dependent on rest and the amount of time available for resting is in inverse relationship to the amount of time that must be spent working. In order to save the lives of future Canadians, health authorities considered legislating some sort of maternity leave, or at least relief, for their mothers. There was no question of this being paid leave nor were employers being asked to make any sacrifices. Legislation considered by the Council was to fall entirely on the woman. It purported to improve her lot but in actuality it ignored one of the most important factors in the life of the working-class woman--the need to earn a living. In fact, the Council did not quite understand the attraction work had for some women. The representative of labor, H. J. Halford, puzzled:

> In the city where I work we have what we call the textile mills, the steel and iron mills and we see women doing the work that men used to do. They work during the day and then they have a child or two to look after at night. Perhaps it is because they want money or want to save it.[15]

He suggested a law preventing women from working if they had two or more children. Helen R. Y. Reid, the representative for child welfare and social service, agreed with this suggestion and requested, in addition, legislation compelling the registration of all pregnancies. This fitted in with the topic of "the race suicide" (birth control) brought forward by Dr. M. M. Seymour, the health representative from Saskatchewan. To combat this evil influence education would have to start long before actual maternal care was needed.[16] Dr. W. F. Roberts, Minister of Health for New Brunswick, agreed. In fact, proper education to encourage the female of the species to devote herself to the production and care of large families should be included in the school curriculum.

> I am referring particularly to girls at a time of their life that they are most receptive to knowledge along any line. They should be instructed regarding the problems of life. A girl about fourteen should be relieved of a good deal of mental work. Girls at that age should be instructed of the possibilities of motherhood.[17]

Calls for legislation to keep women out of the so-called dangerous trades were not limited to health officers. The International Labor Organization meeting in October-November 1919 demanded international minimum standards covering women's employment before and after childbirth, during the night and in unhealthy processes.[18] These types of laws and laws governing the hours and age of employment of children[19] can be seen as other than protective. Soldiers returning from the Great War were faced with a bleak employment situation. The fewer positions there were open to women and children, the more available for men. Restrictive legislation of this type was again urged at the end of the Second World War. A woman health educator writing at that time opined that: "Legislation to prevent women from entering into any form of work that might injure them as potential mothers, should be increased."[20] The Dominion Council of Health did discuss the concept of maternity benefits, something Saskatchewan had recently introduced. However, although it supported Saskatchewan in this and applauded other countries which had passed similar laws, the Council hoped that this would be solved by an awaited minimum wage law. Dr. J.W.S. McCullough, the health representative for Ontario explained how this should work. By guaranteeing a minimum wage, "the working man [sic] should be in a position, where he would be independent of any steps that the Province or State might take in regard to maternity benefits."[21] The first DCH discussion on the topic ended in consensus that the matter was too general to be discussed profitably and a motion was passed to have the Department undertake an investigation of child welfare in Canada, concentrating especially on pre-natal care, infant feeding, hospital and home treatment of maternity cases, extension of public health nursing services, institutional care and its effects on child life, factory life and its effects on maternity cases, employments most injurious to pregnant and nursing mothers, and methods of securing the cooperation of societies and the general public.[22] The new Division started its studies with a visit to each of the provincial capitals at the request of the various health departments. It also took a hand in the formation of the National Council of Child Welfare and started preparing pamphlets.[23]

It was in the release of advice in the form of pamphlets that the Division took its most assertive action. The so-called Little Blue Books were arranged in three series.

The Mother's Series

1. The Canadian Mother's Book.
2. How to Take Care of the Baby.
3. How to Take Care of the Mother.
4. How to Take Care of the Children.
5. How to Take Care of the Father and the Family.

The Home Series

1. Beginning our Home in Canada.
2. How to Build our Canadian House.
3. How to Make our Canadian Home.
4. How to Make our Outpost Home in Canada.
5. How to Prevent Accidents and Give First Aid.

The Household Series

1. Canadians Need Milk.
2. How We Cook in Canada.
3. How to Manage Housework in Canada.
4. How to Take Care of Household Waste.
5. Household Cost Accounting in Canada.[24]

It was the first booklet (written by Helen MacMurchy) in these series that the Division distributed most aggressively. A card marked "This Card is for the Baby's Mother" was given by the provincial registrars to every person registering a birth in Canada. It was meant to be carried home to the new mother who then filled in her name and address and posted it to the Division.[25] The free pamphlet that came in return contained sections that now seem quite alarming. Mothers were urged to start toilet training at six to eight weeks in order to establish beneficial regular habits for life. If the child did not respond upon being placed over a bowl held between its mother's knees, it was to be stimulated by the insertion of a soft rubber catheter into the anus.[26] Under the heading "Don't Kill the Baby," MacMurchy demanded bland food for infants:

> never give the baby "tastes" or "bits" of fish, meat or other things you eat. That is the way to kill the baby. Of course it sometimes fails to kill him, but surely you do not want to risk his life. It is very dangerous to feed such things to the baby too soon. Very often such a baby, if he survives, is delicate or unhealthy in childhood and manhood.[27]

Such scare tactics were also part of MacMurchy's campaign to shame women into the "Canadian" act of breast-feeding. A woman who did not nurse was a bad, an unpatriotic mother--blamed by some for being the greatest cause of infant mortality in Canada.[28] Besides, she claimed, breast-fed babies were better cared for.

> Never let the buttocks or the natal cleft get red and sore. It would be a disgrace. The baby who is nursed by the Mother seldom or never has such a thing happen to him.[29]

Canada was not the only country to push such alarmist literature. A contemporary reformer in the United States felt that the end result of the pamphlets released by the federal Children's Bureau in the United States Department of Labor would be to cause panic.[30] Such results could also be expected in Canada. Not only was the information in the *Canadian Mother's Book* opinionated, it was selective. While pregnancy, getting ready to go to the hospital and care of the baby were covered at some length, there was no mention of the actual birth of the child. Delivery was shrouded in mystique, a ceremony which was the sole reserve of the priest-like physician.[31]

But the fact of the matter was that one of the reasons Canadian infant and maternal mortality rates were so high was because women were not attended at childbed. The Division could release pamphlets and Fall Fair Posters[32] to its heart's content but Canada's mortality rates were not going to drop until no woman need forego help due to lack of money or lack of available facilities. The Division and the Department systematically shirked their responsibility in this matter. For one thing, it would have meant taking on the medical profession. MacMurchy had crusaded against established authority once before and lost. Her failure to force change as medical inspector of Toronto schools in 1910-11 and her consequent resignation did not encourage her to enter another fray.[33] She also was a medical doctor and as a medical doctor she could not accept that anyone but a medical doctor was sufficiently qualified to attend an *accouchement*.[34] Doctors truly believed they had the best interests of women at heart when they campaigned for medical attendance at birth and also, consequently, against midwifery. However, scientific objectivity was not possible for doctors in this matter. The fact could not be ignored that a baby delivered by a midwife meant a lost fee for a medical man. In addition, attendance at childbirth was often a doctor's introduction into a family and possible future fees.[35] It was very difficult for members of the profession to accept midwives as a viable alternative. But as public health officials the members of the DCH and the Department had at least to entertain the idea. Many Canadian women gave birth to their babies without attendance[36] or with only a reluctant neighbor woman to help out.[37] Doctors were simply not available in some areas[38] and in others they refused to come unless guaranteed their fee.[39] Some thought was given to training nurses in obstetrics for service in remote settings but nurses showed little desire either to exile themselves to the backwoods[40] or to tarnish their good name by any association with midwifery.[41]

The remaining alternative, of course, was upgrading the trade of midwifery itself. It was illegal to practise as a midwife in all provinces except Quebec and Nova Scotia and even there they were under some medical supervision. Nevertheless, midwifery was rampant throughout the land because it was needed and because cases were difficult to prosecute.[42] Authorities could have improved matters simply by accepting the *fait accompli*, tying to it regulations to upgrade the qualifications of these women. Success in this, however, was not seen as too likely a prospect. "Midwives are pretty dangerous individuals owing to their fixed ideas and it is pretty hard to train them."[43]

When it was pointed out that properly trained midwives were performing Trojan duty in other countries which had much lower infant and maternal mortality rates, haste was made to demonstrate that the Canadian situation was uniquely difficult.

> In Sweden practically every woman is attended by a mid-wife. They have a very low rate in Sweden, but . . . conditions in a country like that are scarcely applicable to this country. There is a great deal in a country with a population like Canada [that] does not apply in a closely settled country. In this country there are so many nationalities that conditions in countries like Sweden, Switzerland and Denmark are scarcely comparable with this country. Some of the Women's Organizations consider we should have mid-wives in this country, but mid-wives could not handle the situation in a country like Canada at all in my opinion, because how could a mid-wife go out . . . under the weather conditions we have.[44]

In short, Canada is a sparsely settled country which is why it needs midwives but is also why it cannot have them. Weather conditions aside, midwifery was not to be encouraged. Even the Victorian Order of Nurses reacted with distaste to the desire of properly-trained British midwives to immigrate after the Great War. The reason given was that these women "have not the social standing that women in the nursing profession deem necessary."[45] More acceptable alternatives as far as the DCH was concerned were the establishment of small hospitals in remote areas to which pregnant women could come (hopefully in good weather) to deliver[46] or maternity allowances that would allow them to purchase care from the nearest physician.[47]

But neither did rendering possible a doctor's care guarantee a healthy delivery. MacMurchy pointed out that obstetrics was sketchily taught in medical schools and some doctors did not know the basics about childbirth or about the prevention of infection.[48] One member of the Council, Dr. D. H. McCalman of Manitoba, admitted that even new medical students received only four months training in obstetrics but that, even so, he felt that not every case of puerperal sepsis should be blamed on the doctor.[49] The fact of the matter was that it was going to be difficult to carry out any reforms until the true extent of the problem had been grasped. Rowell admitted in 1919 that, although it was obvious that Canada's infant mortality rate was high in comparison to other western countries, vital statistics for the whole Dominion were so patchy that it was impossible to state for sure just how bad the situation was.[50] Was medical attention the key to lowered death rates? Despite belief that this was so,[51] a limited survey of conditions in New Brunswick indicated that a county where little medical help was available had at least as low a maternal mortality rate as other areas where doctors were in sufficient supply.[52] However, there was no problem reaching a consensus that an unsatisfactory situation existed and public health officials,[53] doctors[54] and nurses[55] alike realized that if they wanted to maintain control over the provision of natal care in Canada, they had better act before midwives or others solidified their own positions. As a result of demands from these bodies, the Division of Child Welfare launched an inquiry into maternal mortality in Canada.

The inquiry was to take two years with a cut-off date of June 1926. Research consisted largely of sending letters to doctors, asking them to fill out cards especially prepared to record relevant data and to indicate whether pregnancy was frequently a factor in patients' deaths.[56] The Division spent the major part of its time in 1926 preparing the data so gleaned, supplemented by further information from provincial health authorities.[57] A preliminary report was made before the DCH at the May 1927 meeting.[58] MacMurchy's two-year random survey of physicians regarding instances and causes of maternal deaths resulted in a report that featured no interpretation of data but rather presented it in the form of anonymous letters of advice from physicians and others and dealt with the mortality rate, a comparison with other countries, the question of whether an excessive proportion of women delivered unattended, the high cost of medical fees and the need for ameliorative action. Comparisons were made of the rates in rural versus urban areas and of those in the various provinces. The chief causes of maternal deaths were found to be puerperal sepsis, hemmorhage and eclampsia--all disorders amenable to known methods of prevention and treatment.[59] Despite the information collected, the DCH was still at sea in June 1928 as to just what it should do to bring down the statistics. The great worry was how to indicate that the situation needed improvement without implying blame on the Canadian medical profession for past shortcomings in maternal care.[60] Even the urgings of the Division that collection of vital statistics be upgraded as the first feeble step in the fight against the high rates[61] met with disinterest. A discussion regarding prompt reporting of births and maternal deaths was conducted in a climate of communal ennui among members of the Dominion Council of Health.[62] In the end, over three years' work by the Division boiled down to a report for public information with the public expected to take action and responsibility.[63] According to the Department, this is precisely what happened. Claiming that the report "produced so much interest in the provinces that active measures were taken to reduce maternal mortality,"[64] a ranking official of the Department of Health counted among its practical results the saving of 195 maternal lives in 1931 compared to 1930.[65] He saw this as a tribute to federal leadership and to provincial, volunteer and professional action.

> It is generally believed that this saving of Mothers' lives has come about in consequence of the work of the Division of Child Welfare and especially the Report on Maternal Mortality in Canada, completed on October 28th, 1927, and published January 31, 1928, in which we had the personal co-operation of the Dominion Bureau of Statistics, the Provincial Authorities, Voluntary Societies, two thousand members of the medical profession and others.[66]

It is not necessary to take the Department's word for this. There is evidence that the provinces and many Canadian groups stepped in to take up the gauntlet the Dominion had let drop.[67] One voluntary organization especially dominated the field and it was on this organization the Division relied and later abandoned its work to entirely during the cut-backs of the Depression.

The Department at first had shown a desire to play only a supportive role in child welfare, commending the Canadian Public Health Association in its early efforts to organize all bodies working therein and recommending they all work jointly with the provincial governments. The Department would limit its actions in the field to the use of support and influence.[68] However, after a conference called by the Department met in Ottawa on 19 October 1920, attracting representatives from 120 organizations across Canada interested in child welfare, and resulting in the establishment of the Canadian Council on Child and Family Welfare,[69] an argument erupted in the Dominion Council of Health that demonstrated concern that the Department might lose out to a bunch of ambitious non-professionals. Dr. William F. Roberts, the Minister of Health for New Brunswick, demanded to know:

> This National Council, in their constitution, do they recognize that they are going to work through and under the Department of Health?

Deputy Minister Amyot replied confidently: "Absolutely." He was instantly and ingratiatingly disabused of this notion by Helen Reid, who had taken an active role in the conference.

> I thought it was so excellent of Dr. Amyot to announce to the Conference that the nationally organized body would not work "under" but "in co-operation with" [the Department] and it will be the attitude which we will follow. We want to emphasize co-operation but we don't want to antagonize any voluntary association. We want to work with the Public Health Officials just as closely as possible. There would be co-operation and advice if requested from the Department of Health.

Roberts reacted paternally.

> You can speak of co-operation and my idea is this, you can call it what you like, but let them submit what they are going to do to the Department of Health and the Department of Health, like a parent, will endorse it if it is possible and if it is in accordance with Public Health Legislation ideas.

Reid let her ladylike mask drop and precisely outlined the Department's lack of power in this matter.

> I think in the Meetings of all Public Health Officials, emphasis will be laid on Public Health direction[. When] you realize this National organization is going to include people who are interested in Child Welfare from the Labour, Educational and Delinquent points of view, you cannot expect them to accept dictation from a Public Health official. At the same time I think we all agree in spirit and I think we can be left to steer a safe course. I do not think Public Health work in this country can get on without co-operation between Public Health Officials and the voluntary organizations. There are voluntary organizations in this country doing good work without the least help from the Public Health Officials. You have got to recognize that many of them want that co-operation and stimulus but they are not going to be driven. Dr. Amyot said that the Department here would be ready to give advice, co-operation and counsel but there would be no dictation.

Unbowed, Roberts asked that the meaning of co-operation be defined. Mrs. William [sic] Todd, representing the rural women of Canada and the only other woman on the DCH, tried to smooth the waters:

> I think that in co-operation, while I recognize the point that there must be a final Court of Judgment and naturally we would

> look for that in this Federal Department of Health, still there is in the word "co-operative" so much of reaching out, strength and stimulus that I think the dangers that may be foreseen by some as possible in some of the Provinces or throughout the Dominion can be left to the time when they would appear.

The point had been made. If these ladies were any indication, child welfare auxiliaries would be self-deprecating but firm. Dr. Gordon Bell, the provincial medical health officer of Manitoba, saved face for his fellow health officials by suggesting that the solution be that the Department would limit itself to final say over the medical aspects of child welfare.[70]

But the truth of the matter was that the Department never paid out enough money to allow it to call the tune. That it would never make a large cash commitment was evident early on. In May 1920, to a request by two of the provincial representatives that the federal government make meaningful grants to carry on intensive work in maternal and child welfare on the grounds that this was a national concern, Amyot replied that the limits of the Department virtually confined it to the collection of information to foster any possible legislation considered by the federal government and to distribution of propaganda in the form of moving pictures, posters, lantern slides and educational literature. Otherwise, all he could offer was a tentative scheme to supply temporary health officers to help any local association wishing to carry on child welfare work.[71] After the establishment of the National Council, the Department did make available an annual grant of first $5000, then $10,000, to assist the new agency in its work[72] but Amyot soon made it clear that this should not be expected to increase.[73] By 1923, Amyot was advising voluntary agencies to approach not the federal division for aid and co-operation but the provincial governments.[74] Except for an abortive scheme to field, in concert with the Canadian Medical Association and the Canadian Nurses' Association, a force of "Home Helpers" to be called the "Home Service Nursing Corps,"[75] the Department stuck closely to liaison and publicity work.[76] It did release some useful information--besides the maternal mortality survey, a hospital map of Canada which indicated the location and number of beds available for maternity cases in 1925. It took an interest in a scheme to segregate young first offenders in Canada's penitentiaries and expressed concern over the care of children sent to Canada on their own by immigration organizations.[77] But it is obvious that throughout the decade, the Department never envisioned its Division as the foremost champion of the cause of Canadian children. The provinces were even asked to bear the full responsibility for protective legislation for women and children in industry.[78] However, the provinces were having trouble finding funds for the child and maternal welfare campaign themselves--not one of them had a separate Division of Child Welfare[79]--and one volunteer organization easily dominated the field.

The Canadian Council on Child and Family Welfare[80] had never perceived the problem of infant and maternal mortality as being purely of a medical nature. Although it petitioned the Department, usually through the DCH,[81] for changes in the health side of the question, it held to the faith in social work made so apparent at the October 1920 meeting. Demands were still regularly being made, as they had been before and after World War I, to do something about mother and child conservation.[82] As the Department still failed to take any real initiative,[83] the Council had a virtual vacuum in which to expand. Under the aggressive leadership of Charlotte Whitton--who already was quite well known in the field of social work, among other things, being the Canadian representative to the League of Nations Commission for the Protection and Welfare of Children and Young People[84]--the greatest expansion took place after 1926. The Council embarked on a series of conferences, exhibits and publications to advertise the extent of maternal and infant health problems. Whitton's approach was at odds with MacMurchy's: she firmly believed and flatly stated that infant and maternal mortality were more than just medical problems. Over MacMurchy's objections, the Department removed itself altogether from the field in 1932, as an economy measure. MacMurchy, well past the traditional age, was retired and her Division was closed down. All duties were transferred to Whitton and her Council.[85] Although this necessitated a larger grant, the Department expected to save money which was, after all, the prime justification for the arrangement. However, despite Whitton's attempts to wed medicine and social work, the marriage was never a happy one. Within six years, bowing to a renewed surge of reformism, the Department was back in the business of child welfare. The Council, like the Department, had put its faith in information and education. By 1938, the time had come for something more concrete to be done. Child Welfare adherents were lucky in that their cause benefited from some sort of continuity and did survive to flourish under the post-World War II shift of emphasis to welfare. Another reform aimed at improving the quality of Canadian health was not so long-lived.

Housing, unlike child welfare, could in no wise be seen as a problem amenable to medical solutions. Its future was doomed from the point at which it was included in a Department of Health strongly controlled by medically trained officials and influenced by the medical profession in general. The federal Housing Act, passed by order-in-council under the War Measures Act in 1918,[86] and originally administered under a separate Housing Committee of the Cabinet, was transferred to the Department of Health on 1 November 1919.[87] The move was immediately under attack, Rowell defending it by portraying housing as a prophylactic against disease, surely a function of the proposed new department.

> I am sure that the members of the House will agree that after all the most important thing is not to cure disease but to prevent it. The most important thing is to endeavour to create conditions favourable to good health rather than to treat disease after it has developed. In connection with the health of the people, no question is more important than good sanitary conditions. I think it would be a natural development that the administration of the Federal Government's housing policy would be entrusted to a department like this.[88]

He was still offering defence in 1920, again stressing that "good housing bears so close a relationship to the physical and social welfare of the people that it constitutes a proper branch of the Department of Health."[89] But like too many of the Department's activities, the Housing Division disappointed. It did not head a comprehensive campaign for better housing but simply a scheme to build some houses for veterans--much needed but hardly a blow for better health for the general population.

Although the Housing Division set standards, researched housing conditions and advised on materials and sites, its basic duty was to administer a federal loan to the provinces to be used by them in turn to make loans to provide houses for returned veterans, their widows or their widowed mothers.[90] All provinces but Alberta passed their own housing acts and all but Alberta and Saskatchewan took part in the scheme.[91] By 1924, the year the program was shut down, loans totalled over twenty-three million dollars and 6244 houses had been erected in 179 municipalities.[92] Without the loan the Division had too little to do--or really it had too few resources to deal with too much. The imminent demise of Housing as a separate division became apparent in 1922. The departmental report for that year announced that the mere provision of houses was not enough.

> As expressed by the leading public health authorities of the North American Continent, in the last analysis healthful homes are dependent upon the interaction of biologic, economic, social, educational and political forces, many of which are beyond the control of individuals. In a broad consideration of the problem, therefore, more attention must be given in the future to the numerous phases of heredity and eugenics, industrial organization and economic returns, sociological elements, educational opportunities, public health education, and political ideas as transmuted into legislative enactment and civil interest. It is insufficient to point out the existence of poor plumbing, leaking roofs, and unlighted rooms, the inroads of insects, the existence of alcoholism or drug addiction, the ignorance of individuals and their poverty, and the presence of the diseased and the defective.[93]

Faced with this heady challenge, the Department folded its own tent and stole away, first by amalgamating Housing with two new additions in 1923[94] and then by fleeing the field altogether the next year. Any further initiative in the field was handled by the town planning division of the Surveys Bureau in the Department of the Interior which put out the *Town Planning Journal*. When Interior moved to close down the division in early 1931, pleading economy, there was some pressure for Health to take it over, thereby returning housing to the proper jurisdiction. The Department refused, pleading economic difficulties of its own.[95]

The concerns with which Housing was amalgamated before its demise were Hospitalization and Sanitation. While Departmental interest in sanitation, in various guises, would survive to revive during the Second

World War, Hospitalization's career was much like that of Housing. Concern for better hospital facilities in Canada stemmed partly from the obvious failure of such facilities to cope with the 1918-19 influenza epidemic. One of the measures the DCH recommended to combat the expected return of the flu was a rapid expansion of Canadian hospitals to provide beds for up to one percent of the population.[96] Provinces were making an honest effort to provide more hospitals, especially in rural areas[97] and similar interest in other countries was demonstrated by a concerted drive by the American College of Surgeons to upgrade hospitals in the United States.[98] However, the course the Department took in hospitalization was once again that of provision of information. Putting this information to work was the task of others. This was made clear from the first. In reply to a letter from the Secretary-Treasurer of the Windermere District Hospital Association asking what effect the new Department would have on small hospitals, the senior federal health official stated:

> I do not think it will have any effect upon them at all, as every care was taken in the preparation of the bill to prevent any interference in any way with provincial or municipal rights.[99]

From 1923 to 1931, the period of its existence, the Hospitalization section of the Department of Health did design hospitals for the Arctic and ran a special survey on tuberculosis sanatoria.[100] Otherwise, it served strictly as an information centre for those wishing to consult it. Much of the information was detailed and valuable, running from standards for insulation to the dangers of combustible anaesthetics in operating rooms, from isolation of infectious cases to problems of static electricity.[101] However, information again proved to be an inadequate spur to action. In 1931, the year before Hospitalization, too, fell victim to Depression budget cuts, the Department bitterly admitted disappointment.

> Canadian hospitals, during the last decade have suffered from serious deficits year by year and the public from whom funds are obtained have [sic] become perturbed by the difficult situations which have so frequently arisen due to these conditions.
>
> Lack of co-ordination, failure to understand basic principles, poor organization and uneconomical arrangements of buildings and plant have been the principal causes of the heavy losses experienced during the past.
>
> Conditions such as these should not be tolerated to-day and there is no reason why they should exist since, with the inception of the Dominion Government Hospital Advisory Services, expert advice on the construction and organization of hospitals is available for all those interested in such institutions throughout Canada.[102]

If the Department gave serious thought to the possibility that neither provinces nor municipalities could afford to apply economy it makes no mention.

Sanitation was the specialty of the Deputy Minister of Health. Amyot had established himself in this work before the Great War and continued after joining up.[103] Innovative measures for rural, urban and industrial hygiene[104] were discussed at early meetings of the DCH but if Amyot wanted to make meaningful efforts regarding sanitation he was held back by the charter of the Department. According to Rowell's speech when introducing the Bill to establish the Department of Health, 26 March 1919, federal jurisdiction in sanitation covered only

> the supervision, as regards the public health of railways, boats, ships and all methods of transportation; the supervision of federal public buildings and offices with regard to the health of civil servants and other Government employees therein; the enforcement of the regulations of the International Joint Commission promulgated pursuant to the treaty between the United States and Great Britain for the prevention of pollution of boundary waters.[105]

Otherwise, sanitation was purely a municipal--at most, a provincial--concern.[106] Hygiene measures remained on the agenda of the DCH but by mid-decade, a definite pattern had formed. Industrial hygiene, by which was meant little more than the provision of clean privies, was left strictly to the provinces.[107] The DCH was not too interested in this matter, even suggesting at one point that "there were too many inspections at present being carried on in Canada" in the area of industrial hygiene and rather than the Dominion entering the field, efficiency could be better attained by rearrangement of bodies already doing this work.[108] The Dominion did have jurisdiction over one type of job site and that was any attached to a Dominion work project. This responsibility fell to the Department through the administration of the Public Works Health Act assigned to it as one of its first duties. On federal work sites,[109] such as the Welland Canal,[110] a federal inspector kept an eye on the adequacy and cleanliness of accommodations and ensured there were ample hospital beds and medical services.[111] The standards set, however, were those already established by the province the particular work site happened to be in[112] so it cannot be said that the Department was breaking any new ground. A similar task, the supervision of standards of sanitation in national parks[113]--especially of swimming facilities[114]--also fell under federal jurisdiction. However, many really pressing and interesting sanitation problems did not and for these all the Department could do was offer its catch-all cure-all, information. Pamphlets and advice were made available on sanitary matters running the gamut from mosquito control[115] to the provision of domestic water supplies and sewage treatment in rural areas.[116] By 1929, the Department had published seventeen pamphlets on the last topic alone.[117] But by far the most important Departmental duty falling within the broad classification of sanitation was the enforcement of the regulations of the International Joint Commission regarding pollution of boundary waters.

The Division of the Pollution of Boundary (later Inland) Waters had almost nothing to do with the pollution of boundary (inland) waters. What it did was administer regulations passed by order-in-council of 9 June 1923 regarding drinking and cooking water on ships navigating the Great Lakes and later also those on Canada's inland waters.[118] To ensure that ships adhered to the regulations, members of the division (numbering four engineers and one assistant by 1931[119]) went aboard all Great Lakes passenger and freight steamers to take test samples from all tanks of potable water.[120] The fact that this indeed had little to do with the pollution of boundary waters was soon pointed out to the minister responsible. William A. Boys, the representative for Simcoe South, queried when the matter appeared in the House:

> Does this item correctly indicate the purpose intended? I cannot quite see why the water that is used on these ships is called "boundary waters."

Béland replied truthfully enough that:

> It is the water on boundary-water ships.

Boys, however, considered this a non-answer.

> I can understand that all right, but that is not what the item says.[121]

It is a pity really that the Division's grandiose title should have left it open to ridicule. In actual fact, it was doing a very important job. Whereas drinking water elsewhere in Canada was supposedly subject to some sort of regulation, provincial or municipal, water on Great Lakes vessels was subject to none before the Joint Commission ruling. This posed a danger not only to those on board these ships but to those who might come in contact with them later.

> The transient population of some of these vessels may, in the course of a few months or a year, be equivalent to the normal population of a large city, and as such it is worthy of serious consideration. To-day this floating city may be a focus of infection for a dangerous communicable disease. To-morrow, before any suspicious symptoms develop this transient population may have scattered, spreading sickness to cities and other communities throughout the whole country.[122]

The dangerous communicable disease in question was typhoid fever, a disease from which sailors on Great Lakes ships suffered more "than any other class."[123] Cases had recently been on the increase and had reached a total of fifty among seamen and passengers in 1923. In tandem with the inspections, the Division also ran an educational campaign in the winter months when officers and engineers were free from their ships and offered mid-winter lectures on safe water supplies at centres where students qualified for marine certificates. By 1924, the number of typhoid cases on the Great Lakes reported to federal authorities had fallen to 31, by 1925 to 13 and by 1929 to three.[124]

The Division did express some actual concern for the state of the waters themselves and there are indications that, earlier in the decade, the Division was expected to handle the problem it took its name from. Population was steadily increasing along the shores of the Great Lakes, as a result of which some rivers draining into the Lakes had, according to United States authorities, already been polluted beyond the possibility of purification. The Lakes were, due to their quantity of water, still considered unpolluted but it was feared that the constant input of the river system would in a short time render this not so. Forcing ships to take on water from certified clean sources was only seen as a preliminary step to the cleaning up of the Lakes when it was introduced in 1923. But by 1926, the only other step taken was to set regulations restricting the areas in which the ships could dump water into the Lakes.[125] The attack on water pollution never went beyond this nominal attempt--industries and communities on shore went untouched by federal restraints. When the Division did expand it did so into the guarantee of safe drinking water on the railroads. Concern about sanitation on trains had been evinced in the DCH as early as 1920, although at that time, the discussion centred on the disposal of human waste.[126] The matter was referred by the Department to the railways for rectification.[127] By 1929, the talk had shifted to the control of drinking water and the provision of separate cups on international trains.[128] Some headway was being made in this by 1929[129] and in 1930, the regulations were expanded to include interprovincial, as well as international railroads.[130] There was another form of travel, growing in popularity, which also presented a sanitation problem. The new mode of transportation of the new age--the motor car--allowed people to stop and start at will. This led to a new phenomenon entirely: the tourist camp. Quebec was so alarmed about the unsanitary possibilities of such camps that it launched a program to improve the facilities of small town hotels for tourists and their cars. The Quebec representative to the DCH advised other provinces to do the same, especially those in the prairies where lack of rain would allow people to settle for a week or so. A special committee recommended that regulations be drawn up for the whole country but with some consideration for local conditions; that this draft be submitted to the provinces for approval; that private camps be licensed; and that the federal Division prepare the inevitable pamphlet.[131] The Dominion did nothing more in the field. While people in motor cars might have been travelling interprovincially and sanitation on interprovincial modes of transportation was the concern of the federal authorities, the places they stopped at--the tourist camps--were always in one individual province and it was to the provinces that control of sanitation was left. In fact the same can be said of sanitation in general. In 1930, the Dominion centralized all its sanitary duties into a new Division, that of Public Health Engineering. Its only duties were administration of the Public Works Health Act and the Pollution of Inland Waters Act.[132] Innovation had to wait until the Second World War when need for material spurred the establishment of a Division of Industrial Hygiene.

In addition to the information put out by its various divisions, the Department originally had an agency designed expressly to release publicity. Publicity and Statistics only lasted as a separate division for two years but the Department continued to provide a great deal of detailed information to individuals and groups throughout the decade. The first activity of the Division of Publicity and Statistics was to assemble a library Department officials could consult in an effort to answer their own and others' questions.[133] Heretofore the federal government had had no specialized library of this type.[134] Neither had the provinces. The need for such provision was made painfully clear by the failure of all Canadian health authorities to lay their hands on relevant information during the flu epidemic. The provinces, as well as the Dominion, now started working to remedy this state of affairs.[135] Throughout the decade and beyond, the Department would amass vast quantities of printed reference material.[136] This was to supply the information that would serve as the basis for provincial action. The Department went to great pains to ensure that it did not waste time and money on work already done or being done by the provinces. It asked for copies of all provincial health publications to stock the library and to give it an idea of what needed to be done.[137] A master list was also drawn up of all provincial holdings in films and slides.[138] Before its early demise the Division of Publicity and Statistics itself printed ten books and provided slides and film reels on health topics.[139] With its disbandment, the separate divisions each took over management of their own publications and statistics was signed over permanently to the Dominion Bureau of Statistics [hereinafter DBS]. However, the Department was still expected to work with the DBS in the collection of health statistics and this would prove to be a long-standing irritation.

Reliable morbidity and mortality statistics for every field of health in Canada were both needed and lacking. Better collection was necessary so that authorities could understand the extent of the problems they faced and so that they could recognize any advances and retreats. It is difficult to grasp in these days of constant questionnaires and computers the difficulties facing anyone wanting to obtain accurate and standard statistical information early in this century. Together, the Department and the DBS would do battle against their own ignorance, the ignorance of others, the realities of budgeting and downright resistance. The first matter to be considered was a standard and useful form on which to have information recorded. The DCH took much trouble in working with the DBS to produce such an item.[140] By the end of 1924, a suitable postcard format had been decided upon.[141] A related problem involved the expense of sending completed forms back through the mails. The DCH began petitioning for franking privileges at its second meeting, arguing that the proper collection of vital statistics not only aided crime prevention and promoted "the security and moral tone of social life in general," but was absolutely needed for public health work.[142] The Postmaster General changed the regulations in 1923 to allow all forms sent to the DBS to travel free of charge.[143] These two obstacles overcome, the authorities ran straight into resistance from both the medical profession and provinces.

By law, physicians had to report births and deaths and certain diseases. In reality, the profession was excessively apathetic in this matter.[144] The doctors on the DCH admitted this was so but felt it was a little vicious to go after the profession to do more "free work." In Ontario, physicians were generally prosecuted for failure to return birth and death notices but not if they failed to notify diseases.[145] In effect, the profession was being allowed to break the law and impressions were that notification was getting worse. The situation had to be regularized in some manner before it broke down altogether. While dismay was expressed at "the contempt of the profession for laws," it was suggested that doctors might be more punctual were they paid. Despite one DCH member's objection that he had already tried this, and another's that it was the municipalities and not the federal government that should pay,[146] the Council favored this solution.[147] However, nothing was done about the matter. Doctors' reporting of statistics remained at an unacceptable level,[148] and the DCH abandoned the topic for more fruitful discussions. The DBS carried on alone, introducing new forms in 1929 but still lamenting the lack of response as late as 1933.[149]

Perhaps the provincial representatives of the DCH avoided making a fuss about the mote in the profession's eye because they carried a sizeable plank in their own. As part of Canada's membership in the League of Nations, the Department was required to prepare an annual report for the *International Health Year Book*. Every year, the Department sent the relevant questionnaires, averaging about ten pages, to the various provinces and every year had hot coals heaped upon its head for its efforts. Although Manitoba seemed to manage the task with little trouble, Ontario said the Department would have to consult on its own various voluntary organizations and the hygiene departments of several universities if it wanted all the data asked for. Although rebellious, this was certainly more useful than New Brunswick's contribution. The chief health officer of that province refused to supply information for the League's benefit at no cost to itself: "I for one at least, am not so well paid for extra endeavors."[150] The League was very understanding about the difficulties, possibly because it was facing the same resistance from Great Britain. It offered to publish anything Amyot could come up with but between 1924 and 1929 he could come up with nothing. In 1930, he managed to scrape up enough information to make an appearance.[151] Failure of the provinces to comply with the request of the League for information was not only due to apathy but to hostility. R. B. Bennett summed up the basis for such an attitude in the House of Commons. As a member of the League, Canada had to comply with certain health conventions. In effect the federal government was guaranteeing that the provinces would come up to certain League standards. Bennett and the provinces saw this as an infringement of provincial rights.[152] The Department would have difficulties getting the provinces to take responsibility for their part in the notification of morbidity and mortality until the end of the Depression. At that time, reporting would improve as part of the new surge of reform and, like so many other health-related activities, during World War II it would boom.[153] Publicity would also be renewed as a result of the war, a new Division of Publicity and Health Education being established in 1939.[154]

But before the new initiatives of the late Depression could come about, there had to be a drastic change in attitude towards public health matters in this country. The truth was that the postwar fervor that had fired the establishment of the Department of Health had been a nine days' wonder. After the stimulating debate on the original establishing Bill in 1919, the House of Commons had subsided into a state of apathy on health matters. Discussions regarding health were regularly scheduled, in both the House and the Senate, for as late as 11 p.m., often on a Friday evening.[155] During 1926 and 1927, health rarely hit the agenda at all,[156] causing the *Canadian Public Health Journal* to write concerned editorials.[157] Harking back to Senator James Lougheed's assertion before the Senate in May 1919 that "[there] is probably nothing like a war to discover the steps that should be taken for the protection of the public health,"[158] the *Journal* spoke almost regretfully of the intervening decade of peace:

> It would appear that it almost requires a war to make citizens think about the need for saving lives for the nation or of the importance of keeping the largest possible number of citizens healthy and fit. Possibly the reason is that only the obvious impresses most of us.[159]

The obvious would once again impress the people of Canada. It would come during the Depression and its urgency made more glaring by another war. In the meantime, the reform dreams of the Great War awaited burial. Had the iron been struck while it was hot, real progress might have taken place. As it was, the excitement just seemed to seep away. The federal government had not been the only group to witness this type of dissolution and it would not be the only one to live to regret failure to take the main chance. In a report on nursing education written in the mid-1950s, the compiler made a statement that could be applied to the fact of all post-World War I reform proposals.

> Instead of the radical change which might have taken place in the 1920's, we have worried through thirty additional years of confused effort, dealing with symptoms rather than with the disease itself. Certainly some improvement in detail has been effected but the fundamental condition has remained the same.[160]

However, the same sort of sorrow was not evident when it came to abandoning the Department of Health in 1928. The climate was rather one of hostility--not at the forsaking of health but at the degradation of Soldiers' Civil Re-establishment [hereinafter SCR]. This latter department had been established in 1918 to provide for the pensioning, retraining, demobilization and medical treatment of veterans.[161] However, by 1928, the war over for ten years, the only remaining significant concern was the administration of pensions for the disabled and the unemployable.[162] The government commissioned a three month study by P. F. Ross and Sons of Montreal to see if it could save money and improve service by amalgamating the SCR with the other war left-over, Health. The report was positive[163] and the Governor General's speech promised the establishment of a single department where two had existed before.[164] The reaction was immediate and violent. How could the government tie the future of Canada's aging veterans to something so trifling as the nation's health? The inability of J. H. King, the

Minister of Health, to grasp the extent of this indignity was blamed on his inability to see that one partner was far too good for the other.

> The Soldiers' Civil Re-establishment Department is more important than the Department of Health, and if the minister would consider it in that light perhaps there would not be as much objection.[165]

It was joked that the bill should be called the narcotic bill as it was designed to put to sleep the soldiers' department.[166] Concern was overwhelmingly aimed at the fate of the SCR, not at that of Health.[167] Peter McGibbon, who had carried on a long tradition of saying nasty things about the Department of Health--although always with an idea to making it do more--worried instead about the fate of federal health responsibilities.

> What is the reason for doing that [the amalgamation]? Is it because the Department of Health has nothing to do? Or is it because there is nothing to be done for the returned soldiers? It must be the one or the other. If there is anything to justify the existence of the Department of Health, it must surely have something to do, and if it has enough to do it should not have a large and important department like the soldiers' department tacked on to it under the same deputy minister.[168]

King simply deflected all criticisms by pointing out that two or three years before the leader of the Conservatives had suggested the soldiers' department be abolished and other members of the opposition had supported an amalgamation similar to the one now taking place.[169] By the middle of May 1928, the bill had passed third reading in the Senate;[170] the shotgun marriage had been effected. The Department of Pensions and National Health would last until 1944. In the end it would be McGibbon who would be proved right--Health would be the loser in the relationship. Sixteen years after the amalgamation, the budget for pensions was approximately fifty times that for health.[171] It was from this weakened position that federal health authorities would have to deal with the continuously worsening conditions of the Depression years.

7

NOTES

[1] Florence H. M. Emory, *Public Health Nursing in Canada: Principles and Practice* (Toronto: Macmillan, 1945), pp. 19-22.

[2] James Roberts, Medical Health Officer for Hamilton, Ontario. Quoted in Neil Sutherland, "'To Create a Strong and Healthy Race': School Children in the Public Health Movement, 1880-1914," *History of Education Quarterly*, XII (Fall 1972), 304.

[3] For example, Alberta, the first province to set up a district nursing branch, in 1919. See Collins, pp. 14-6.

[4] For example, the National Council of Women. See Buckley, "Ladies or Midwives," pp. 132-49.

[5] N. W. Rowell, Commons, *Debates*, 1919, p. 1165.

[6] *Report, Health, 1920*, p. 22.

[7] Buckley, "Ladies or Midwives," p. 140.

[8] Buckley, "Efforts to Reduce . . .," p. 77.

[9] Commons, *Debates*, 1928, p. 2014.

[10] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 1.

[11] *Ibid.*, 5th meeting, 19-21 October 1921, n.p.; 6th meeting, 13-15 June 1922, pp. 1-2 of memo for McCullough.

[12] *Ibid.*, 7th meeting, 28-30 November 1922, McCullough's notes.

[13] *Ibid.*, 14th meeting, 26-28 October 1926, pp. 22-4.

[14] *Ibid.*, 1st meeting, 7-9 October 1919, p. 1.

[15] *Ibid.*, 2nd meeting, 17-19 May 1920, p. 11.

[16] *Ibid.*, pp. 10-1.

[17] *Ibid.*, p. 12.

[18] *Ibid.*, pp. 3-5.

[19] *Ibid.*, pp. 11, 21.

[20] Emory, p. 367.

[21] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 2.

[22] *Ibid.*

[23] *Report, Health, 1921*, pp. 22-3.

[24] *Ibid.*, *1924*, pp. 43-4.

[25] *Ibid.*, p. 44. The Division reported receiving "thousands" of these cards in this, the best year yet of this program.

[26] Helen MacMurchy, *The Canadian Mother's Book* (Ottawa: King's Printer, 1923), pp. 99-100.

[27] *Ibid.*, p. 114.

[28] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 19-20.

[29] MacMurchy, p. 84.

[30] Frances Bradley; Lloyd C. Taylor, Jr., *The Medical Profession and Social Reform, 1885-1945* (New York: St. Martin's Press, 1974), p. 74.

[31] Things have not changed much in fifty years. The current version of this book, *The Canadian Mother and Child* (Ottawa: The Health Program Branch of the Department of National Health and Welfare, 1976) does contain an appendix "for the benefit of the person who may suddenly have to assist at a baby's birth" (p. 161) and a brief chapter describing what happens to the woman's body during labor (pp. 63-7). However, it constantly draws up short of giving the reader full information, advising her instead to "call her doctor" (e.g., p. 59).

[32] *Report, Health, 1922*, pp. 36-9; *1923*, pp. 41-5; *1924*, pp. 43-4.

[33] Buckley, "Efforts to reduce . . .," pp. 79-80.

[34] Buckley, Ladies or Midwives," p. 140.

[35] *Ibid.*, p. 137.

[36] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 10.

[37] Buckley, "Efforts to reduce . . .," p. 78.

[38] PAC, DCH Minutes, 11th meeting, 15-17 December 1924, pp. 20-36.

[39] Buckley, "Efforts to reduce . . .," p. 78.

[40] Buckley, "Ladies or Midwives," p. 142.

[41] *Ibid.*, p. 136.

[42] *Ibid.*, p. 142.

[43] Amyot, PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 11.

[44] McCullough, *ibid.*, 18th meeting, 4-6 December 1928, p. 10.

[45] Quoted in Buckley, "Ladies or Midwives," p. 144.

[46] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 11.

[47] *Ibid.*, 18th meeting, 4-6 December 1928, p. 14; 11th meeting, 15-17 December 1924, pp. 20-36.

[48] *Ibid.*, 11th meeting, 15-17 December 1924, pp. 20-36.

[49] *Ibid.*, 18th meeting, 4-6 December 1928, pp. 10-11.

[50] Commons, *Debates*, 1919, p. 1165. See Chapter 1 for rates.

[51] PAC, DCH Minutes, 11th meeting, 15-17 December 1924, pp. 20-36.

[52] *Ibid.*, 8th meeting, 19-21 June 1923, p. 12.

[53] Buckley, "Efforts to reduce . . .," p. 78.

[54] PAC, DCH Minutes, 14th meeting, 26-28 October 1926, pp. 17-20.

[55] Buckley, "Ladies or Midwives," pp. 143-4.

[56] PAC, DCH Minutes, 14th meeting, 26-28 October 1926, pp. 17-20.

[57] *Report, Health, 1927*, pp. 65-7.

[58] PAC, DCH Minutes, 15th meeting, 10-12 May 1927, letter from secretary.

[59] Buckley, "Efforts to reduce . . .," pp. 78-9.

[60] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, p. 26.

[61] *Report, Health, 1926*, pp. 30-1.

[62] PAC, DCH Minutes, 18th meeting, 4-6 December 1928, p. 11.

[63] Buckley, "Efforts to reduce . . .," p. 79.

[64] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 23.

[65] *Ibid.*, p. 24. However, there were also fewer births.

[66] *Ibid.*, p. 25.

[67] Buckley, "Efforts to reduce . . .," pp. 80-1.

[68] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 6-9 and p. 2 of Resolutions.

[69] *Ibid.*, 3rd meeting, 25-26 October 1920, p. 2.

[70] *Ibid.*, pp. 11-3.

[71] *Ibid.*, 2nd meeting, 17-19 May 1920, p. 5 and p. 3 of Resolutions.

[72] Buckley, "Efforts to reduce . . . ," p. 76.

[73] PAC, DCH Minutes, 6th meeting, 13-15 June 1922, p. 2.

[74] *Ibid.*, 9th meeting, 11-13 December 1923, pp. 43-5.

[75] *Report, Health, 1926*, p. 29. This idea was not exactly new. See Buckley, "Ladies or Midwives," pp. 136-7.

[76] For example, *Report, Health, 1924*, pp. 38-40.

[77] *Ibid., 1926*, pp. 31-2.

[78] PAC, DCH Minutes, 6th meeting, 13-15 June 1922, agenda item 10.

[79] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 25.

[80] The general files for the Council are found in PAC, RG 29, vols. 992 and 993.

[81] PAC, DCH Minutes, 13th meeting, 8-10 December 1925, letter from Frances Tessier of the Council.

[82] *Ibid.*, 14th meeting, 26-28 October 1926, letter from Bert Merson to Toronto papers.

[83] For example, *Report, Health, 1928*, pp. 68-70 and *1930*, pp. 117-24.

[84] *Ibid., 1926*, p. 32.

[85] Buckley, "Efforts to reduce . . . ," pp. 82-3.

[86] Blyth, p. 156.

[87] *Report, Health, 1920*, p. 22.

[88] Commons, *Debates*, 1919, p. 1171.

[89] *Ibid.*, 1920, p. 3556.

[90] *Report, Health, 1920*, pp. 22-4.

[91] *Ibid., 1921*, pp. 23-4.

[92] *Ibid., 1924*, pp. 28-31.

[93] *Ibid., 1922*, p. 29.

[94] *Ibid., 1923*, pp. 30-4.

[95] PAC, RG 29, vol. 19 (file 10-3-1, part 2) Letters from Town Planning Institute of Canada and National Council of Women to the Department, replies and inter-office memos, 5-13 May 1931.

[96] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 4.

[97] For example, Alberta. Collins, pp. 13-4.

[98] PAC, DCH Minutes, 7th meeting, 28-30 November 1922, pp. 1-2.

[99] PAC, RG 29, vol. 19 (file 10-3-1, part 2) Letter, Montizambert to A. E. Fisher, 2 June 1919.

[100] *Report, Health, 1928*, pp. 70-6.

[101] See especially *ibid., 1929*, pp. 128-30 and *1930*, pp. 124-7.

[102] *Ibid., 1931*, p. 151.

[103] Peter McGibbon, Commons, *Debates*, 1928, p. 2018.

[104] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, pp. 2-3; 2nd meeting, 17-19 May 1920, pp. 16-8.

[105] Commons, *Debates*, 1919, p. 843.

[106] *Report, Health, 1923*, pp. 33-4.

[107] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 24-6.

[108] *Ibid.*, 6th meeting, 13-15 June 1922, p. 2 of McCullough memo.

[109] See PAC, RG 29, vol. 280 (file 370-4-10, part 2).

[110] *Report, Health, 1926*, pp. 44-5.

[111] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 31.

[112] PAC, RG 29, vol. 262 (file 360-1-2).

[113] *Report, Health, 1923*, pp. 33-4.

[114] PAC, RG 29, vol. 271 (file 369-4-2).

[115] PAC, RG 29, vol. 380 (file 375-6-3).

[116] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 27-30; 6th meeting, 13-15 June 1922, n.p.; 8th meeting, 19-21 June 1923, p. 7.

[117] *Report, Health, 1929*, p. 130.

[118] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., p. 29. For general files, see PAC, RG 29, vols. 263 and 272.

[119] F. M. Brickenden and J. R. Menzies, "Water and ice supplies on common carriers," *CPHJ*, XXII (Nov. 1931), p. 573.

[120] *Report, Health, 1924*, pp. 49-54.

[121] Commons, *Debates*, 1925, p. 3607.

[122] *Report, Health, 1925*, p. 37.

[123] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, p. 41.

[124] Brickenden and Menzies, pp. 570-3.

[125] PAC, DCH Minutes, 9th meeting, 11-13 December 1923, pp. 41-3; 14th meeting, 26-28 October 1926, pp. 14-7. *Report, Health, 1927*, pp. 32-42.

[126] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, p. 39.

[127] *Ibid.*, 9th meeting, 11-13 December 1923, pp. 53-4.

[128] *Ibid.*, 17th meeting, 19-21 June 1928, pp. 37-8.

[129] *Ibid.*, 19th meeting, 18-20 November 1929.

[130] Brickenden and Menzies, pp. 570-1.

[131] PAC, DCH Minutes, 12th meeting, 11-13 June 1925, p. 15 and six page report at end.

[132] *Report, PNH, 1930*, pp. 84-7.

[133] *Report, Health, 1920*, pp. 19-20.

[134] PAC, RG 29, vol. 19 (file 10-3-1) Letter from Montizambert to Laurence J. Burpee, Secretary of International Joint Commission, 26 May 1913.

[135] PAC, RG 29, vol. 1192. Volume deals with possible recurrence of epidemic.

[136] For examples, see PAC, RG 29, vols. 188, 189, 192 and 1145-1277.

[137] PAC, DCH Minutes, 1st meeting, 7-9 October 1919, p. 3; 2nd meeting, 17-19 May 1920, pp. 39-40.

[138] *Ibid.*, 9th meeting, 11-13 December 1924, p. 2.

[139] *Report, Health, 1921*, pp. 21-2. See also PAC, RG 29, vol. 119 (file 188-1-1) regarding distribution of films.

[140] PAC, DCH Minutes, 6th meeting, 13-15 June 1922, n.p.; 9th meeting, 11-13 December 1923, pp. 19-20.

[141] *Ibid.*, 11th meeting, 15-17 December 1924, pp. 36-7.

[142] *Ibid.*, 3rd meeting, 25-26 October 1920, pp. 4-5.

[143] *Ibid.*, 9th meeting, 11-13 December 1923, memorandum.

[144] *Report, Health, 1924*, p. 28. For the sparseness of statistics at this time, see correspondence between Amyot and Arthur Wilson, medical health officer of Saskatoon, 21 December 1923 - 17 January 1924; PAC, RG 29, vol. 40 (file 35-2-14). Wilson wanted to know the cost to Canada for each communicable disease.

[145] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 8.

[146] *Ibid.*, 9th meeting, 11-13 December 1923, pp. 10-11.

[147] *Ibid.*, 12th meeting, 11-13 June 1925, p. 13.

[148] *Report, Health, 1926*, p. 25.

[149] E. S. Macphail, "The Medical Certificate of Death," *CPHJ*, XXIV (Feb. 1933), 65-71.

[150] PAC, RG 29, vol. 26 (file 25-1-3, part 2) Letter from G. G. Melvin to Heagerty, 11 Feb. 1930.

[151] For correspondence and questionnaires, see *ibid.* and vol. 25 (file 25-1-3, part 1).

[152] Commons, *Debates*, 1928, pp. 1967-75.

[153] See PAC, RG 29, vol. 530 (files 312-1-1 and 312-1-4).

[154] *Report, PNH, 1939*, pp. 155-8.

[155] For example, Commons, *Debates*, 1929, p. 2622 and Senate, *Debates*, 1928, p. 564.

[156] See Commons, *Debates*, 1926 and 1926-27.

[157] "Parliament should be interested," editorial, *CPHJ*, XX (Oct. 1929), 510-11.

[158] Senate, *Debates*, 1919, p. 288.

[159] "Parliament should be interested," p. 510.

[160] Edith K. Russell, *The Report of a Study of Nursing Education in New Brunswick* (Fredericton: University of New Brunswick Press, 1956), p. 25. Quoted in Canadian Nurses' Association, *Spotlight on Nursing Education. The Report of the Pilot Project for the Evaluation of Schools of Nursing in Canada* (Ottawa: Canadian Nurses' Assn., 1960), p. 1.

[161] Strong, pp. 82-3.

[162] PAC, RG 29, vol. 19 (file 10-3-1, part 2), P.C. 2347.

[163] J. H. King, Commons, *Debates*, 1928, pp. 2011-2.

[164] *Ibid.*, p. 2.

[165] Arthur E. Ross, *ibid.*, p. 2014.

[166] Ross, *ibid.*

[167] See *ibid.*, pp. 2450-63, 2784-9.

[168] *Ibid.*, p. 2013.

[169] *Ibid.*, pp. 2014, 2012.

[170] Senate, *Debates*, 1928, p. 571.

[171] "Canada Needs a National Department of Health," editorial, *CPHJ*, XXXV (May 1944), 204.

It is rather a strange thing that
the moment a member speaks on either
of two subjects this house immediately empties itself. Those two
subjects are bad whiskey and good
health. Either of these subjects
will stop a riot and disperse a
crowd anywhere. It is unfortunate
but it is so.
--Thomas E. Kaiser in the House of
Commons, 23 May 1929.

Chapter Five

WHOSE RESPONSIBILITY?

THE BREAKDOWN OF HEALTH CARE IN THE DEPRESSION

On 19 June 1928, Deputy Minister John A. Amyot appeared before the Dominion Council of Health to announce that the Department of Health would soon amalgamate with the Department of Soldiers' Civil Re-establishment. The amalgamation would be accomplished basically only through the sharing of a deputy minister; the health department, he affirmed, would experience little change.[1] He meant the last part of this statement to be an assurance. However, there was really little comfort to be taken from the prospect of the maintenance of the *status quo* in this division of the federal government. Even the minister in charge was hard-pressed to rally justifications for congratulation regarding the past functioning of the Department. Accused of heading a department that "has no more to do with health than with mines,"[2] J. H. King fell back on the insistence that the tasks previously handled by other departments that had been transferred to Health at its inception were better looked after under Health and that the Department furthermore had made headway in at least one field--the staying of the flood of infected and incompetent immigrants into Canada.[3] In other words, the federal department had taken over and made certain limited embellishments to that cornerstone of nineteenth century public health policy--simple quarantine. However, it could not be said that the federal government had managed to eradicate any of the post-War problems that had spurred its establishment. Reformers at the time demanded a Department of Health that would take action against four threats to a high standard of Canadian health: venereal disease, tuberculosis, infant mortality and feeblemindedness.[4] A decade and a half later, a member of parliament rose to demand that the Department of Pensions and National Health take action on five fronts: venereal disease, tuberculosis, child and maternal mortality, insanity and cancer.[5] None of the original four threats to Canadian well-being had been brought under control. A new threat had been added. The reasons for the inability of the Department of Health to deal with its assigned tasks were the same ones that would hamper the Department of Pensions and National Health. Supposedly the federal government had jurisdiction over public health but public health was ill-defined. The boundary between it and medical care, the supposed reserve of the provinces and the medical profession, was hazy. Any attempt to establish a firmer border arbitrarily would put both public health and medical care in false positions. Jurisdiction over all matters to do with public health and medical care in Canada needed a thorough sorting-out. The Depression provided the scenario for renegotiation--the breakdown of the former system became apparent and not one of the responsible parties was eager to fulfill its current duties, let alone to add new ones. All wanted a change and a change was definitely needed.

Grant Fleming, prominent in Canadian health reform, writing in mid-Depression, summed up the problem of dividing public health from medical care. Such a division, he argued, could only be found wanting.

> In order to gain a better perspective of the present-day relationship between public health and the provision of organized medical care, it is desirable to look back upon the development of the modern public health movement. By doing so, it will be seen how public health has been led inevitably first to become interested [in], and then to assume responsibility for the provision of an ever-increasing amount and variety of medical care.
>
> During the period when public health concentrated its attention upon environmental conditions, the provision of medical care was not included in the public health programme, but just as soon as Pasteur's work revealed man as the reservoir of his own infections, attention was shifted from the environment to the individual. Isolation and quarantine were altered from routine measures founded largely upon fear to procedures based upon a reasonable understanding of the manner of spread of communicable diseases.[6]

As an example pertinent to Canada, the author cited the on-going struggle against tuberculosis. A high standard of public health (the preserve of the Dominion) necessitated a low TB rate. However, the only way to prevent the disease was to treat its victims (the preserve of the medical profession), preferably in hospitals (the preserve of the provinces).[7] Another Canadian health writer, Allon Peebles, commenting at about the same time, tried to sort out the confusion of jurisdiction produced by this state of affairs. He made no attempt to separate federal and provincial functions. He lumped together as health functions of the state: legislation to prevent anti-social behavior, prevention and control of communicable diseases, sanitation, mental health, tuberculosis, public health education, care for poor patients and support of general hospitals. To private medical practice he assigned most aspects of curative medicine: maternity care, diagnosis, care of the individual, and surgery. Still, after making the above assignments, he was left with something he was forced to designate the "twilight zone." In this hazy area lurked health problems of national importance which no authority was eager to claim as wholly its own. Significantly, in this underworld existed three of the concerns the federal Department of Health had originally been established to solve: diagnosis and treatment of tuberculosis and venereal disease, and maternity and infant care. Also unclaimed was responsibility for immunization and vaccination.[8] Much concern was evinced at the beginning of Canada's Depression regarding this murkiness in public health jurisdiction. However, the stress was not on making sure that all aspects of health and medical care were covered but rather on guaranteeing that none were funded to excess.

For the Interprovincial Conferences of January 1933 and September 1934, the federal health branch produced not less than nine documents dealing with possible overlapping of health care in Canada.[9] The documents reveal a maze of confused detail. The basic reason for which a Department of Health had been established in 1919--the rationalization of public health provisions for Canada--was obviously far from realized. It is difficult to see how things could have been spread out over more federal departments, provinces and voluntary organizations. Federal jurisdiction alone spread over eight agencies in addition to Pensions and National Health. Even that Department split health activities into two parts. There was no doubt that the National Health branch was the major organ of the federal government in this field. Its jurisdiction covered:

Quarantine; care of lepers; fumigation of ships.

Medical examination of immigrants.

Medical care and treatment of sick mariners.

Control of narcotic drugs.

Pollution of boundary waters; supervision of water supplies and sanitation on trains and boats; sanitation on aeroplanes; supervision of medical care and treatment of men employed on public works.

Control of standards and purity of foods and drugs, including supervision of exported shellfish; licensing of biological products; testing of potent drugs, bacteriological and serological products.

Supervision of proprietary or patent medicines.

Taxation of medical accounts for federal government.

Examination of civil servants in connection with sick leave and superannuation.

Co-operation with provincial, territorial and other health authorities regarding conservation of child life and promotion of child welfare.

Venereal diseases, to a limited extent.

In addition, the Pensions side of the Department handled:

Medical care and treatment of war pensioners.

Unemployment relief to small pensioners.

The other eight federal agencies and their health activities were:

Department of Agriculture

Supervision of meat and canned food.

Supervision of health of animals.

Meat inspection.

Tuberculin testing of cattle and testing of cattle for undulant fever.

Department of Indian Affairs

Supervision of the health of Indians.

Department of the Interior--Northwest Territories Branch

Medical care and treatment of Eskimos.

Department of Labor

Prohibition of the manufacture, importation and sale of matches made with white phosphorous.

Wages and hours of labor.

Department of National Defence

Medical care and treatment of soldiers.

Medical supervision of men in relief camps.

Royal Canadian Mounted Police

Medical care and treatment of police.

Dominion Bureau of Statistics

Collection of data on births, marriages and deaths.
Morbidity and mortality reports of infectious diseases.

National Research Council

Direction of investigations into tuberculosis.
Health hazards in spray painting.
Study of the use of iodized salt.
Standardization of X-rays and radium.
Studies in parasitology.
Analysis of alkaloids of poisonous plants.[10]

The activities of the provincial health departments were outlined in much less detail. Provinces varied as to how many of the following they handled, and how well.

Collection of vital statistics.
Control of communicable diseases.
Treatment and control of venereal disease.
Treatment and control of tuberculosis.
Maternal hygiene.
Infant, pre-school and school hygiene.
Food and milk control.
Community sanitation and sanitary engineering.
Health education.
Cancer control.
Heart disease clinics.
Industrial hygiene.
Mental hygiene and mental hospitals.
Inspection of hospitals.
Dental services.
Training schools for nurses.[11]

Outside the governmental realm many voluntary organizations were also interested in health. The federal government made grants to several:

The Canadian Welfare Council.
Canadian Committee for Mental Hygiene.
Health League of Canada.
Canadian National Institute for the Blind.
L'Association Canadienne Française des Aveugles.
L'Institut Nazareth de Montréal.
Montreal Association for the Blind.
Canadian Tuberculosis Association.

Victorian Order of Nurses.
St. John Ambulance Association.
Canadian Red Cross Society.
Canadian Dental Hygiene Council.[12]

The sole organ provided to coordinate these disparate functions was the Dominion Council of Health. Its membership consisted of the senior executive health official from all nine provinces and of five lay representatives--one each appearing on behalf of farmers, labor, rural women and urban women, and a scientific adviser on public health.[13] The Department, too, was represented, in the person of the Deputy Minister who usually chaired all DCH meetings. Great claims were made for the effectiveness of this Council. At the end of its fourth meeting, it congratulated itself thus:

> The Dominion Council of Health has again justified its existence in that the highest medical authority in each province has been able to lay his views and recommendations before those of the other provinces; and understanding has been reached on many points in connection with the administration of Public Health in the various provinces, such as could hardly have been done by any other means.[14]

A Department report produced more than a decade later, confirmed this good opinion. The DCH had proved its worth as a clearing-house where questions could be aired in open discussion.

> Inestimable benefit has been reaped by each of the provinces. Where before there was doubt, misunderstanding and, at times, a clash of interest, there is now mutual understanding, progressive administration, and uniformity of procedure.[15]

In actual fact, the DCH had no power to do anything. This was explicitly stated in the House during the debate on the bill establishing its existence,[16] and reaffirmed by the Deputy Minister in 1928 during the upheaval of amalgamation with Pensions.[17] This lack of authority was apparently one of its appeals. All health officials would be able to get together in a friendly situation, to talk and to exchange advice. Nobody would be forced into doing anything unless convinced it was the correct procedure. At the same time, the federal Department could parry accusations of passing the buck on certain health matters.[18] However, accusations of passing the buck still were voiced and the Council's record did not turn out to be a very successful defence. By the beginning of the Depression, the Dominion Council of Health had sat twice a year for a decade. J. H. King, the responsible Minister, felt it was impossible that all those hours of talk did "not produce some good."[19] But, in truth, many of these hours of talk took the DCH directly up blind alleys. Examples of matters on which it had spent considerable time to little or no avail were treatment facilities for drug addicts;[20] uniform provincial regulations for disinfectants;[21] co-operation in halting a scheme, potentially dangerous to human life, to manufacture a virus to commit germ warfare on rats;[22] cleanliness standards for converted materials used for stuffing upholstery, bedding, toys, etc.;[23] co-operation among the provinces for the safe shipment of deceased persons across provincial borders;[24] and, a very important issue, the likes of which would haunt the DCH, the federal Department and the provincial governments throughout the Depression, interprovincial organization of reciprocal care for sufferers from TB and other dangerous communicable diseases moving from one province to another.[25] Not established with the idea of being an active instrument by which to force change and co-operation, it also failed to become an instrument through which reform could be achieved. The cracks in the Council's façade widened under the pressures of the Depression. Between 1929 and 1933, the Canadian national income declined nearly forty percent.[26] People who had before been able to buy health care for themselves could do so no longer.[27] The Canadian health care system, like other care agencies, was caught totally unprepared. Despite pressing need for action, the DCH failed to capitalize on its position as a firmly established council of the leading health officials in the nation. In mid-decade it was still, rightly, dismissed in the House for being little more than a debating club.[28] It was clear that this, the federal government's only coordinating agency for health matters in Canada, was not going to be strong enough to deal with the problems of this time of crisis. Too much reorganization was needed. Jurisdiction over public health in Canada needed to be re-thought.

Supposedly the big barrier to rationalization of health and medical care in Canada was the British North America Act. Trotted out at various times as a delaying tactic when the government in power wanted to avoid action on health reform, the BNA Act was referred to as "a very present help in time of trouble;"[29] an Aladdin's lamp which could "contort itself into any shape, it seemed, except the one the majority of Canadians wanted;"[30] and as a "shelter" behind which many a health Minister had found refuge.[31] Indeed, it had become so worn an excuse even by the early days of the Depression that the Minister was embarrassed when once again he felt compelled to put it through its paces: "We must have regard--if I may whisper the word--to the British North America Act, which I know is always suggested as the last resource."[32] It is now taken for granted that the BNA Act assigned the major responsibility for health care to the provinces.[33] The Privy Council's reaction to Bennett's New Deal proposals during the Depression itself certainly decided in favor of provincial jurisdiction.[34] Although the rigidity of the Council's interpretation of the act has been questioned in later years,[35] it was upheld by enough authorities[36] at the time to make it stick. Arguments in favor of a strict interpretation of the Act were usually couched in terms of "provincial rights,"[37] which the federal government, at least in this matter, seemed to hold particularly sacred. As a matter of fact, the provinces would have been delighted to surrender some of their rights in the field of health in return for a little much-needed federal assistance. It was the federal government which spurned all advances.

This had not always been the case. At the time the Department of Health was established, a federal official lamented "the complication caused by Canada having left all matters relating to health to the Provinces, which we can now see was a great mistake."[38] The first real use of the provincial rights gambit came with the federal attempt to withdraw the VD grants in the mid-1920s. Parties arguing for maintenance of the grants argued that the BNA Act did not apply: it in no way made health jurisdiction clear.

> Health is not mentioned in this Act. Health Departments have been established in the municipalities first and then by the provinces because the necessity was realized locally first. Surely the health of the men, women and children is a national matter fundamentally.[39]

An editorial in Canada's leading health journal opined that: "The British North America Act does not place the responsibility for health matters on the provinces as a casual reading of the Act will convince any observer."[40] A letter to one of the major Toronto papers, and signed "Osgoode Hall," stated in 1926 that the BNA Act allotted much of what came to constitute public health to neither the provinces nor the Dominion for the simple reason that health was not a question at the time.[41] Similar objections were voiced in the House.[42] Perhaps, all financial things being equal, the federal government would have softened and taken a more active and generous role in Canadian public health. After all, the Department did not cut off the VD grants altogether in the mid-1920s, although it cut them back. And it was known to give special help in emergencies, such as in the serious typhoid outbreak in Montreal in the spring of 1927.[43]

However, the warning that the federal government did not intend to be generous in times of trouble was given in the House early in the Depression. Quoting the vague passages referring to health directly from the offending Act,[44] health Minister King found in it sufficient ammunition to take a strong stand.

> We are carrying on the government of Canada under what is known as the British North America Act, which states definitely that matters pertaining to education and health should be dealt with locally. . . . There seems to have been a desire on the part of those who framed our constitution to give to the people of the provinces local control, which I think is very essential in health matters. Now, it may be suggested that we should continue to leave the control locally with the municipalities or provinces. I am sure that if the Dominion government should enter this field they [sic] would be a party to granting money in the expenditure of which they had no control or no say. Many public bodies have come to Ottawa asking that we invade the provincial field and give subsidies and make grants, but the Prime Minister . . . has made himself very well understood by stating that the principle is vicious.[45]

Reiteration came from a new Minister under a different government in 1931, 1934 and 1935.[46] Government policy was borne out by the actions of the Department. Early in the Depression, the Dominion Council of Health passed three resolutions that it hoped might serve the cause of health in the country. Claiming that trachoma and venereal disease were both national rather than provincial problems--the former because the federal immigration service had let it into the country, the latter because World War I was held accountable for the epidemic supposedly sweeping the nation--the DCH asked that the federal Department provide treatment for trachoma and re-establish the VD grants. As a sop thrown to those concerned about federal finances, the Council suggested that at the same time the Dominion arrange to save itself some small money by delegating sanitary supervision of federal buildings to the local municipal health authorities. These suggestions were forwarded in a memorandum to the Minister by the chief executive assistant of the Department.[47] There was also a personal, covering memo sent. It advised that the first two requests be denied but that the last be examined for possibilities.[48] In another memo of the same vintage, the same Department official advised that:

> The Dominion should deal only with such public health matters as are exclusively national, or such interprovincial public health matters as cannot satisfactorily be controlled by the provinces.[49]

A definite policy needed to be drawn up so as to avoid

> the confusion and uncertainty that are caused by requests of Provincial Governments, Members of Parliament, organizations and the people, for assistance by the Dominion in health matters that are exclusively provincial in character.[50]

Demands that the federal government soften its stand were to come from various groups and individuals throughout the Depression. Some, for example, the Canadian Medical Association, did not accept the interpretation of the Act.[51] Others said if the Act really left health matters to the provinces, then the Act was an ass and should be changed.[52] In response to this latter tactic, Charles G. Power, who served as the Minister of Pensions and National Health during most of the last half of the Depression, gave the strongest, and silliest, reaction to this suggestion ever made in public on behalf of a federal government. The specific motion that sparked this particular debate had been to change the BNA Act so that the Dominion could provide medical exams and treatment for those in need of such help. Power was especially upset by the support of J. S. Woodsworth for this motion.

> The hon. member for Winnipeg North Centre would be the first to agree with me that he would not expect me, at any rate--and I do not think I would expect him, if he were in my place--to go to any province in Canada and say, "I ask you to permit me, or to permit the government of which I am a part, to amend the British North America Act, so that I may impose coercion on the citizens of your province and place upon them the obligation of coming before a doctor to be examined." I would thereby be violating the elementary principle of the British North America Act with respect to civil rights. Then I would have to go a step farther--I would have to call on my right hon. friend the Minister of Justice . . . and ask him to lend me his mounted police so that they could go forth into the country districts and round up or corral the recalcitrants who refused to have their teeth cleaned or their chests thumped.[53]

He had, however, absolutely no objection if the provinces wished to round up and examine their citizenry.[54] In face of such agitation, the motion was withdrawn. But the truth of the matter was that public intransigence aside, the Department did not turn a totally deaf ear to the increasingly urgent cries for help. In 1932 and again in 1933, a Department official assured the representatives on the DCH that the federal government recognized that public health was more than just a provincial matter.[55] And in 1938, the obstinate Power himself agreed before that body that although he regarded responsibility for health as strictly provincial, he would see what he could do about providing federal grants.[56] From the force of sheer necessity, the federal government would by the end of the Depression come to take over much more in the field of social services in general than was ever granted under the BNA Act.[57]

Aside from the federal and provincial governments, the other major organized body directly concerned with Canadian health care was the medical profession. One of the problems the Department would always have in dealing with this group was the conviction of that group that the Department was at least partly a creature of its own invention. The Canadian Medical Association had certainly lobbied for a federal health department for some years prior to its actual establishment[58] and the entire profession was congratulated in the House for "having, as a result of their consistent labours, at last secured a Public Health Act that . . . meets with the approval of everybody."[59] Parts of the population were not happy about the hold Canadian doctors had over the delivery of health care and were expected to have over the new Department. Segments of the public press accused the profession of pressuring for its establishment simply to gain official representation of its views at the federal government level.[60] Christian Scientists, fearing that the new Department would force them to go to doctors, launched a write-in campaign.[61] If it were not precisely true that the profession had created and would control the Department, doctors--particularly as represented by the CMA--would exercise considerable influence. Doctors held a special status in the eyes of most of the Canadian population, of the politicians and certainly of Department officials. They were the experts and the healers. It was taken for granted that their needs and wishes must be taken into account when it came to reforming any part of the Canadian health care system.

Another factor that militated in favor of special treatment of the medical profession by most health officials and Ministers was that most of these gentlemen were themselves members of the medical profession. They had profited from the same training, subscribed to the same ideals, and supported the same methods as the group with which they were to negotiate, if not actually to direct. One doctor, later to become for a short period Minister of Health, stood in the House to claim that "if you look over the history of health matters throughout the world, you will find that there has been no advance in sanitation or public health that medical men were not foremost in helping forward."[62] Another doctor, while actually serving as Minister, referred to the medical profession as "that splendid branch of humanity."[63] To be fair, they were not alone in this adulation. Non-professionals also stood in the House to make similar votes of confidence in Canadian doctors.[64] Nowhere would doctors' special status be more apparent than in the attitude of Parliament and the Department towards the prosecution of physicians suspected or even guilty of drug offences. It was not considered cricket to use the evidence of either decoys or addicts to gain a conviction against a member of the medical profession.[65] It was asked that doctors who were addicted themselves be given more leeway and not be prosecuted even if they supplied narcotics to children. Due to their addiction they could not be considered responsible for their acts and the Department should not treat them the same as any other criminal involved with narcotics.[66] Although the Narcotics Division saw that charges were laid against some medical offenders, it did so reluctantly.[67] Instead, the chief of the Division preferred to obtain from the offender a guarantee that he would "take a cure."[68] In 1941, he estimated that 120 Canadian doctors had benefited from this option over the past twelve years.[69]

In addition to this deference to the medical man as a special person, there was a tendency on the part of the Department to use the medical profession as a source of objective opinion in matters in which it could not possibly be objective. Because of this, the profession did have some control over Departmental activities and policy--never official control, but control all the same. This power was most prominently put into force when it came to safe-guarding the predominant place of doctors in health care delivery systems. For much the same reasons as it objected to mid-wives, the profession resisted the professionalization of optometrists,[70] chiropractors, osteopaths and homeopaths,[71] as well as faith healers with no pretense to training at all.[72] It also sought to reduce the flow of foreign doctors into Canada, on the grounds that there was no room for them, except in certain parts of the west, due to large graduating classes from Canadian medical schools.[73] Provincial[74] as well as federal governments helped the profession to protect its own monopoly in this field. When chiropractors brought a bill before the Yukon Council in 1940 aimed at gaining licensing for that trade, J. J. Heagerty, by that time a very highly placed and influential Department official tipped off the CMA and suggested it get together a representation. When the bill came up before Council, he himself made a statement against it.[75] Heagerty had supported the CMA in this fight from within the Department for at least a dozen years by this time. In 1928, when the College of Physicians and Surgeons in Quebec moved against drugless practitioners of all types, he threw what Department weight he could behind the cause.[76]

The Department and the profession also worked hand in hand in other matters. The former sought the latter's approval on such items as a proposed vaccine for the prevention of anterieur poliomyelitis[77] and the propriety of including aspects of treatment in a public health propaganda film on venereal disease.[78] It is true that the profession did not always get its way[79] and that the Department also solicited opinions from other bodies which were not capable of taking an objective stand[80] but time after time, the Department asked for and took into account the advice of Canadian doctors on matters that involved their own regulation. And when medical care systems broke down under the force of the Depression, the first reaction of the Department was to leave new initiative for change in the hands of the Canadian Medical Association. In late 1934, the Minister of Pensions and National Health, Col. D. M. Sutherland, appeared before the DCH and lauded the report the Committee of Economics of the CMA was drawing up on the current emergency[81] and in early 1935 he gave the same applause before the House of Commons. He firmly stated that the Department would not move to make an independent investigation of the health breakdown until the CMA recommendations had been thoroughly gone over.[82] He insisted that it would be hasty and useless for the Department to act on its own because

> in any move of the kind which a government, either federal or provincial, might make, it is essential to consider the matter and discuss it with the medical associations, because on their cooperation the success of the whole thing depends. The committee has made a comprehensive report considering the subject, I think, from every angle, and the present situation is this: The Canadian Medical Association has sent that plan to each provincial body, and the provincial bodies in turn have sent it to every individual doctor throughout the country for his observations and any suggestions he desires to make upon it. The comments and suggestions which the individual doctors make will come back through the provincial bodies to the Canadian Medical Association and from their replies and the original plan it will be possible for the association to evolve some plan which they can recommend to some government. It does seem to me that until that plan is evolved and ready to be presented to a government, steps should not be taken in the matter, because there is no use going into a thing of this kind at random and without seeing just where you are going.[83]

This course of action ignored one basic fact. This was that, although both the Department and the profession were concerned with the maintenance of a high standard of Canadian health care, they were fundamentally at odds over the way such service could be guaranteed. This conflict existed long before the start of the Depression but it was under the stress of economic stringency that the issue had finally to be sorted out.

Doctors became alarmed at the effect of the Depression on health care in Canada not just because of their role as safeguarders of Canadian health but because they were the sellers of a service that could be afforded by an ever smaller number of consumers. Like everyone else in the country, doctors needed work--or at least paid work. It was said that, in the search for a living wage, some doctors had been forced to take jobs as taxi drivers and manual laborers; others had gone on relief.[84] It was also said that, in an attempt to carry on their work, some doctors had mortgaged their possessions, unable as they were to collect fees from their destitute patients.[85] By mid-decade, some doctors in the Winnipeg area banded together to attempt to force the municipal government to shoulder some of the load when it came to free medical service for the poor. Those involved signed a pledge.

> I undertake to refuse free medical service in the office, hospital or home to any individual in receipt of relief, unless an emergency exists. An emergency is one in which life is in imminent danger and for which immediate action is required. This is to take effect on and after the fifteenth day of February, 1934, unless the civic and/or municipal authorities concerned have made satisfactory arrangements with our committee.[86]

This was a move dangerously close to strike action, something that was anathema to the medical mind. However, it was admittedly unfair to the profession to ask them to provide free service. This was admitted in the House of Commons.[87] After all, no other profession was asked to do so, nor were manufacturers expected to supply free goods. However, while they were eager to be paid, doctors also worried about the fate the profession might suffer if it delivered itself over even partially to state subsidization. As one editorial in the *Canadian Public Health Journal* asked: "Is medical relief the fore-runner of state medicine?"[88] But it was clearly time for the profession to act and doctors realized it.[89] In 1933, the Saskatchewan representative to the DCH urged such action, warning that "it behooves the medical profession to be prepared with some fairly definite leadership, while public opinion [is] still fluid."[90] Perhaps acting on this advice, Saskatchewan doctors did lead an agitation that led to the petitioning of all four western provinces and the federal government itself[91] but nothing concrete was achieved.

One of the problems with medical initiative in this field was that fear of regulation on the part of doctors would hamper any negotiation of a system of subsidized medicine satisfactory to both the state and the profession.[92] One doctor admitted in the House of Commons that the characteristic individualism pervading the medical profession meant that it had "probably not advanced or kept step with the organization of other fields of activity."[93] Doctors were used to being controlled by other doctors, from training school on. While some members of the public felt that this had led the profession into an unpleasant situation of its own making, wherein doctors had failed to provide proper organization of care,[94] had raised their fees too high[95] and even sullied the good name of the trade through an outrageous abuse of the "old boy network,"[96] doctors on the whole worried that the relegation of even part of this control to another body would destroy individual initiative[97] and the much-advertised "personal element" in doctor-patient relations.[98] The party taking the other side in the negotiations would also have trouble with the concept of regulating the profession. While it could be argued that doctors knew little about public health,[99] it could not be argued that public health officials were similarly ignorant of the doings of private physicians. They were doctors and they were active in the profession. This was especially true of the federal Department. According to the constitution of the Canadian Medical Association, two members of the CMA General Council had to be officials of the Department, one of which must be the Deputy Minister.[100] It went without saying that the profession would have strong influence on any government decision as to its fate.[101] The solutions meant to alleviate not only the suffering of impoverished, unhealthy Canadians but the financial woes of physicians were introduced under shadow of uneasy negotiation. The scheme eventually settled upon by the federal government--compulsory health insurance--would suffer from too close concern for the feelings of the profession and then would suffer the final indignity of being rejected by that profession when it saw a better way out.

There was one other group that would be called on to provide some health care during the Depression. These were the voluntary organizations. These agencies had supplied money for clinics, medical personnel and other appurtenances during the better times and the demands on them would be even greater in the 1930s. Public health officials had always had problems working with this arm of the health care system, as witnessed by their difficulties with the Canadian Council on Child and Family Welfare. But again, as with the Council, the Department would abandon some of its responsibilities to them as the Depression progressed. This was a shift that would give the voluntary agencies some definite power when it came to pressuring for reform at the end of the decade. The 1920s had seen almost continual spurning of advances on the part of the federal government. The private organizations, notably the Red Cross, had asked for some official recognition from the new Department at the time of its inception--if nothing else, at least a seat on the DCH. The Deputy Minister refused, stressing that the lay members on the Council were meant to represent "classes in the Community" rather than organized groups. He did assure the Red Cross, however, that it would be consulted regarding work within its sphere.[102] But the Department never quite came to terms with what constituted the proper sphere of the voluntary agencies. Even when the Red Cross formally requested a decision on just what the federal and provincial governments wanted it to do, the only answer the DCH provided was that it, and others like it, must accept their auxiliary status.[103] At the same time, the agencies were urged to organize on their own, preferably under the umbrella of the Canadian Public Health Association[104] which would grow to have close ties with the federal Department.[105] Fortunately, these agencies did not hang around waiting for direction. During the 1920s, both the Red Cross and the Victorian Order of Nurses provided basic health care, especially in the rural areas.[106] The voluntary agencies mostly just expanded into vacuums that the governments had either ignored or been unable for various reasons to fill. The Department pretty much kept hands off the agencies in their expansion, content with taking part in their activities only through a series of continually dwindling grants. By 1929, the Dominion Council of

Health had managed to decide on only one area of predominantly voluntary jurisdiction--disaster relief of the type so badly needed and so totally lacking at the time of the Halifax explosion a decade before or in the event of an extensive flood or fire.[107] Indifference in general towards these agencies seemed to be on the wane by the end of the decade. The federal Department agreed to head a joint meeting of voluntary associations in late November 1929.[108] But by that point, it would be too late. Deep Depression would soon be upon the country and private money would be counted on more and more for provision of simple public health service.

One of the major providers of private funds was not even Canadian. The Rockefeller Foundation had been granting funds for the care of Canadians since the mid-1920s. Rockefeller grants funded public health in more countries than Canada. Starting in 1925, the funds went in this country to the establishment of schools of hygiene; fellowships for medical health officers, public health nurses and personnel from government health departments; full-time county health units in some provinces; home nursing; and education regarding nutrition and health practices.[109] Grants also went to various Canadian voluntary associations, for example the National Committee for Mental Hygiene.[110] The provincial representatives on the DCH were not happy about having to accept these foreign inroads into their territory. They asked that the federal government, instead, provide the needed money[111] on the grounds that "we had better be the 'mother' rather than the Rockefeller people."[112] The Depression changed opinions regarding the acceptance of American charity. Speeches were given in the House in favor of more Rockefeller funds.[113] The provinces relied even more heavily upon the grants[114] and the DCH devised a special survey for which it asked for Rockefeller funds. The survey would not only give a comprehensive view of health activities in Canada, it would hopefully provide a position for Dr. A. Lessard, lately the Quebec representative on the Council "who has been let out of the Quebec government employ . . . and is really in need of the opportunity for employment."[115] Just as federal health officials became less jealous over their jurisdiction as the Depression proceeded, so did the provinces and the medical profession. By the end of the decade, the climate was right for re-negotiation. At first a new spirit of co-operation would be fostered additionally by the threat and then the actuality of a war. However, as that crisis also passed, the iron cooled. The lessons learned in the Depression would not really lead to a thorough sorting-out of Canadian health plans and policies.

And the lessons really did not even lead to amelioration of poor conditions during the Depression either. In the early years, no one expected that the present bad situation could really go on much longer and when the economy turned around, everything would go back to normal. Reform could not thrive in this environment. Why strive to adjust to an anomalous situation if matters will shortly return to normal? The Department's reaction to this philosophy was to concentrate on easing the federal government's financial embarrassments rather than on attacking the problem of crumbling health care in Canada. It cut back most of the grants to voluntary agencies by ten percent.[116] The DCH considered cutting back to one meeting a year.[117] And, of course, the venereal disease grants were cancelled altogether and the Division of Child Welfare abolished. In 1932, Heagerty made an honest assessment of the Department's actions in this time of crisis.

8

> There is not a great deal to report in the way of activity in the department; we have been more or less marking time during the past year, and I think perhaps that has been common to all departments of health throughout the country.[118]

In actual fact, the Department did not merely mark time during the first half of the Depression; it retreated in the provision of all its services. The annual reports for the period show no initiative in new fields and an abandonment of old responsibilities.

Some responsibilities could be reduced under quite happy circumstances--for the simple reason that they were no longer needed, at least to such a great extent. Great savings came in the divisions that had always received the lion's share of Department funding. The most expensive of these was Quarantine. Shipping was down because of the economic difficulties. Canada and the United States managed to capitalize on this by accepting ships examined and passed by each other.[119] The great quarantine stations, already recognized as obsolete by 1931,[120] were officially declared so in 1936.[121] Their abandonment became imminent with amendments to loosen maritime regulations the next year.[122] With ships no longer required to lay over for medical examination of crew and passengers, the old quarantine establishments were largely closed down, saving the Department twenty percent of its total annual expenditures.[123] Those other federal quarantine hospitals, the leper colonies at Bentinck Island and Tracadie, were left unchanged throughout the decade but had never been a major expense anyway. There was some talk of ending the isolation of these people, perhaps as an economy measure, on the grounds that "leprosy is not a contagious disease at all" but criticism of the Department by the DCH for even making the suggestion was so strong that the matter was dropped quickly.[124] Another saving came in the nature of cut-backs in the Immigration Medical Service. By 1930, there was some indication of anti-immigration feeling in Canada. The accusation was that laborers were brought in simply to dilute wages and to provide consumers for the manufacturers.[125] By 1932, immigration was being actively discouraged[126] and the number of immigrants into Canada fell from over fifty thousand in 1930-31 to just over ten thousand the next year to about six thousand in 1932-33.[127] As a result, the Immigration Medical Service was not much needed and seven officers were transferred back to Canada and two let go. Inspection ports were cut back from nineteen to seven and clerical staff from twenty to nine.[128] The roster doctor system was still kept on but business was so bad that each doctor's area was expanded to a radius of fifteen miles to guarantee enough would-be emigrants to maintain his continued interest in the service.[129] Interestingly enough, the decrease in shipping and immigration did not lead to a similar decrease in demand for the services of the Marine Hospitals division. Perhaps this is a comment on the health of workers in the Depression. With fewer vessels paying dues but the same number of applications for treatment, the Department was forced to shorten the length of time it would treat chronic diseases such as tuberculosis.[130] Another division that seemed amenable to budget paring was Public Health Engineering. By 1933, the Division no longer inspected sanitation on the sites of federal Public Works but simply provided a copy of the Public Works Health Act to government engineers or medical officers on site.[131] Later that year, the Quarantine, Immigration, Sick Mariners and Public Health Engineering Divisions of the Department of Pensions and National Health were grouped together.[132] But while the Depression let the pressure off these divisions, it put the pressure directly on others. Canada's three drug-related divisions experienced a definite upswing in business during the Depression.

The Food and Drugs Division congratulated itself in 1932 for having been spared any severe consequences during the budget economies of that year.[133] The very next year, it started to report a greatly increased workload. This it blamed on the economic crisis which led to keen business competition and in turn to cheaper products and new forms of adulteration. Also, lack of employment opportunities had led some people to start small-time manufacturing operations under total ignorance of the regulations.[134] These latter cases the Division usually corrected rather than prosecuted.[135] To handle the increased work, the Laboratory of Hygiene was moved to more spacious premises in mid-decade. The new lab soon proved inadequate.[136] There was a new wrinkle added to the Division's responsibility--extraordinary sales promotion. This also had to do with increased competition[137] and was fostered by the growing popularity of the radio.[138] While most of the problems the Department dealt with in this field fell under the heading of pure quackery,[139] others involved such thoroughly respectable products as milk.[140] Even perfectly unadulterated and routine samples of spices, vinegar and honey were confiscated by reason of being offered for sale in a fraudulent manner.[141] By the end of the Depression, more than just the Division was concerned about the situation. The Better Business Bureau of Montreal approached the Department in early 1939 asking for co-operation in issuing monthly bulletins on false advertising to advertising agencies and journals. The Department declined on the grounds that:

> At the present time we have so much work in attending to false[,] exaggerated or misleading claims made for food and drugs through various advertising media that, with our present staff, it would be quite impossible.[142]

That same year the Food and Drugs Act was amended to bring it in step with modern conditions.[143] The Proprietary or Patent Medicines Division faced precisely the same problems when it came to advertising,[144] experiencing particular difficulty in combating false claims for quack cures beamed over the border from United States broadcasting stations over which the Department could exercise no control.[145] The Division also had a problem in stopping the manufacture of preparations not sufficiently medicated to prevent their use as alcoholic beverages.[146] As thanks for its work, the Division received complaints that its control was not stringent enough[147] and complaints that it was interfering with the public's right to self-medication.[148]

The Narcotics Division went into the Depression with newly beefed-up legislation passed in 1929.[149] The emphasis on this division was not to cure or care for addicts[150] but simply to dry up the supply of drugs, therefore supposedly reducing the population of addicts.[151] The methods used to achieve this continued to centre on police work rather than health work. The Department bought X-ray, wire-tapping and recording devices.[152] Department agents drove around in cars for hours on the look-out for traffickers.[153] It worked with both the Royal Canadian Mounted Police and United States authorities to prevent smuggling.[154] The head of the Division made great claims for the effectiveness of these measures. In 1935, he stated that narcotics had been ninety-five to one hundred percent unobtainable in cities like Montreal for a period of some months.[155] Unfortunately the conviction that reduction of supply would lead to reduction of demand (much the same as stamping out a virus would result in less infection) proved to be ill-founded. As morphine, heroin and cocaine came under successful control, consumers turned to other sources, notably opium.[156] Opium poppy heads were brought under control 1 January 1933 and the addicts shifted to paregoric and codeine.[157] These, too, were placed under new strictures.[158] A new threat raised its head. Marijuana cigarettes made their first appearance in the departmental reports in 1933 and were considered particularly dangerous to young people, "to whom their use is almost exclusively confined, as all indications point to the fact that their illicit sale usually takes place in cabarets and dance halls where young people, not previously addicted to any form of narcotic, congregate."[159] The Opium and Narcotic Drugs Act was amended in 1938 to make cultivation of the hemp plant (the source of marijuana) a criminal offense complete with mandatory fine and sentence and optional whipping at the discretion of the judge.[160] By 1939, the Division had eradicated cannabis plants found growing on one thousand premises in seven provinces. Most had been planted as windbreaks years before any anti-narcotic legislation or had sprung up from the droppings of birds fed with hemp-laced seed mix.[161] Still, it could hardly be argued that any of the Division's considerably vigorous activities did much for the standard of Canadian health. It is ironic that a health department would keep up expenditures in this area while cutting back or out funds for the amelioration of really serious health problems.

Perhaps it was not so much the Department's abandonment of responsibilities it had formerly taken unto itself that disappointed--although there certainly was objection to its dropping of the Division of both Venereal Disease and Child Welfare--as its failure to rise to the new challenges of the Depression. By mid-decade there would be a pervasive idea that the Canadian standard of health had been eroded by the economic difficulties, that the municipalities and provinces had been asked to do too much when it came to medical relief, that they had not the means to continue, and that the federal government must needs do something. A new surge of reform, not unlike that which led to the establishment of the Department in the first place, would reach strength by the late 1930s and the federal government would take steps to act. When it did so it would step not only into the field usually reserved for the provinces but also into that kept for the medical profession.

NOTES

[1] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, p. 1.

[2] Peter McGibbon, Commons, *Debates*, 1929, p. 2623.

[3] *Ibid.*, pp. 2967-70.

[4] See Chapter 1 above.

[5] H. E. Spencer, Commons, *Debates*, 1934, p. 499.

[6] Grant Fleming, "The Relationship of Public Health to Medical Care," *CPHJ*, XXV (Oct. 1934), 461.

[7] *Ibid.*, p. 462.

[8] Allon Peebles, "The State and Medicine," *Canadian Journal of Economics and Political Science* [hereinafter *CJEPS*], II (Nov. 1936), 476.

[9] Contained in PAC, RG 29, vol. 23 (file 21-1-1).

[10] PAC, RG 29, vol. 23 (file 21-1-1) Interprovincial Conference, pp. 1-2.

[11] PAC, RG 29, vol. 23 (file 21-1-1) Activities of Dominion and Provincial Departments of Health in Respect to Overlapping, p. 2.

[12] *Ibid.*

[13] PAC, DCH Minutes, 8th meeting, 19-21 June 1923, p. 2.

[14] *Ibid.*, 4th meeting, 19-20 May 1921, p. 2.

[15] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division . . ., pp. 34-5.

[16] N. W. Rowell, Commons, *Debates*, 1919, p. 1173.

[17] PAC, DCH Minutes, 18th meeting, 4-6 December 1928, p. 1.

[18] PAC, RG 29, vol. 19 (file 10-3-1, part 2) Correspondence between Francis H. Gisborne, Parliamentary Counsel and Frederick Montizambert, January 1919. PAC, DCH Minutes, 8th meeting, 19-21 June 1923, pp. 2-3.

[19] Commons, *Debates*, 1929, p. 2816.

[20] PAC, RG 29, vol. 236 (file 324-1-2, part 1) and vol. 237 (file 324-1-2, part 4).

[21] *Ibid.*, vol. 39 (file 35-2-4, part 1).

[22] PAC, DCH Minutes, 19th meeting, 18-20 Nov. 1929, pp. 39-41.

[23] PAC, RG 29, vol. 181 (file 300-2-3).

[24] PAC, DCH Minutes, 5th meeting, 19-21 Oct. 1929, 2 page summary; and 6th meeting, 13-15 June 1922, n.p. RG 29, vol. 181 (file 300-2-4).

[25] PAC DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 21-4. BMS, patient file #4001.

[26] James T. Patterson, "Federalism in Crisis: A Comparative Study of Canada and the United States in the Depression of the 1930's," in Victor Hoar, *The Great Depression: Essays and Memoirs from Canada and the United States* (Vancouver: Copp Clark Pub. Co., 1969), p. 6.

[27] PAC, RG 29, vol. 23 (file 21-1-1) Interprovincial Conference, p. 3.

[28] J. P. Howden, Commons, *Debates*, 1934, p. 1686.

[29] J. S. Woodsworth, *ibid.*, 1938, p. 1077.

[30] Leo Heaps, *The Rebel in the House* (London: Niccolo Pub. Co., 1970), p. 101.

[31] H. E. Spencer, Commons, *Debates*, 1931, pp. 1698-9.

[32] Murray MacLaren, *ibid.*, p. 1002.

[33] See, for example, Aucoin, p. 55.

[34] J.R.H. Wilbur, *The Bennett New Deal: Fraud or Portent?* (Toronto: Copp Clark, 1968), p. 5.

[35] See F. R. Scott, "The Nineteen Thirties in the United States and Canada," in Hoar, pp. 180-1 and J.R.H. Wilbur, *The Bennett Administration, 1930-1935*, The Canadian Historical Association Booklets, 24 (Ottawa: CHA, 1969), p. 19.

[36] Brooke Claxton, "Social Reform and the Constitution," *CJEPS*, I (Aug. 1935), 409-35.

[37] Rowell, Commons, *Debates*, 1919, p. 1169. "Parliament should be interested," p. 510. Peebles, pp. 472-3.

[38] PAC, RG 29, vol. 19 (file 10-3-1, part 2) Letter from Gisborne to Montizambert, 10 Jan. 1919.

[39] PAA, Premiers' Papers, file #0433, "Some Facts concerning Venereal Diseases and their control in Canada" [1924?], p. 1.

[40] PAA, Premiers' Papers, file #0433, "The Venereal Diseases Grant," mimeograph of editorial from *CPHJ* [1924?], p. 1.

[41] PAC, DCH Minutes, 14th meeting, 26-28 Oct. 1926, n.p.

[42] T. E. Kaiser, Commons, *Debates*, 1929, p. 2978.

[43] PAC, RG 29, vol. 1232 (file 311-T9-14, parts 1-4).

[44] See Chapter 1 above.

[45] Commons, *Debates*, 1930, p. 219.

[46] Murray MacLaren, *ibid.*, 1931, p. 1002; 1934, p. 1643 and 1935, p. 1065.

[47] PAC, RG 29, vol. 23 (file 21-1-1) Memorandum re The Possible Overlapping where both Dominion and Provincial Authorities are exercising jurisdiction in reference to public health [1933?], p. 5.

[48] *Ibid.*, Memorandum from Heagerty to MacLaren, 31 Jan. 1933.

[49] *Ibid.*, Memorandum by the Department of Pensions and National Health, Item no. 6--Agenda, Interprovincial Conference, "Overlapping" (Health), p. 2.

[50] *Ibid.*, p. 1.

[51] George S. Young and T. C. Routley, "A Submission by the Canadian Medical Association to the Royal Commission on Dominion-Provincial Relations, Canada, 1937," *CMAJ*, XXXVIII (Mar. 1938), 287.

[52] See debate, Commons, *Debates*, 1939, pp. 1573-97.

[53] *Ibid.*, p. 1589.

[54] *Ibid.*, p. 1590.

[55] PAC, DCH Minutes, 25th meeting, 31 Oct. - 2 Nov. 1932, p. 32; 26th meeting, 13-15 June 1933, p. 25.

[56] *Ibid.*, 37th meeting, 6-7 Dec. 1938, pp. 14-7.

[57] H. M. Cassidy, *Social Security and Reconstruction in Canada* (Toronto: Ryerson, 1943), p. 26.

[58] See correspondence in PAC, RG 29, vol. 19 (file 10-3-1, part 1).

[59] Francis H. Keefer, Commons, *Debates*, 1919, p. 1378.

[60] *Ibid.*, 1919, p. 1179 (R. J. Manion), p. 1372 (W. D. Cowan), and p. 1378 (F. H. Keefer).

[61] See correspondence in PAC, RG 29, vol. 19 (file 10-3-1, part 2).

[62] Robert J. Manion, Commons, *Debates*, 1919, p. 1179.

[63] Murray MacLaren, *ibid.*, 1932-33, p. 3118.

[64] For example, F. H. Keefer, *ibid.*, 1919, p. 1378.

[65] J. P. Howden, *ibid.*, 1934, p. 1679; Peter McGibbon, J. P. Howden and Robert K. Anderson, *ibid.*, 1928, pp. 4052-7.

[66] Arthur E. Ross, *ibid.*, 1929, p. 2978.

[67] For example, *Report, PNH, 1931*, p. 79.

[68] PAC, RG 29, vol. 236 (file 324-1-2, part 1) Letter from Col. C.H.L. Sharman to Dr. A. Procter, registrar of the College of Physicians and Surgeons, British Columbia, 19 March 1930.

[69] PAC, RG 29, vol. 237 (file 324-1-2, part 4) Letter from Sharman to H. J. Anslinger, Commissioner of Narcotics, Treasury Department, Washington, D.C., 3 Feb. 1941.

[70] PAC, DCH Minutes, 14th meeting, 26-28 Oct. 1926, pp. 38-9.

[71] See PAC, RG 29, vol. 183 (file 302-6-3) and (file 302-6-4, part 1).

[72] PAC, RG 29, vol. 39 (file 35-2-4, part 1) Letter to Department from Dame Veuve Pierre Sicard of Jolliette, P.Q., 1 Feb. 1927. James H. Gray, *The Roar of the Twenties* (Toronto: Macmillan, 1975), p. 224.

[73] See correspondence, PAC, RG 29, vol. 184 (file 302-6-10, part 1) on reciprocal recognition of medical qualifications.

[74] PAC, DCH Minutes, 3rd meeting, 25-26 Oct. 1920, p. 18. Collins, pp. 35-9.

[75] See correspondence in PAC, RG 29, vol. 183 (file 302-6-3).

[76] Among other things, medical experts accused homeopaths of removing tonsils with their fingernails. See correspondence, PAC, RG 29, vol. 183 (file 302-6-4, part 1).

[77] PAC, RG 29, vol. 1199 (file 311-P11-6, part 1) Letter from Heagerty to F. W. Swinburne of Cambridge Society, Montreal, 22 Apr. 1936.

[78] PAC, RG 29, vol. 215 (file 311-V3-18, part 1) Letter from Heagerty to the Secretary of the American Social Hygiene Association, 26 July 1922.

[79] For example, regarding relaxation of narcotics restrictions on prescriptions by doctors. PAC, RG 29, vol. 858 (file 20-C-33, part 1) Memo from the CMA to the Minister of Pensions and National Health [early 1935?].

[80] For example, the Canadian Pharmaceutical Manufacturers Association and individual manufacturing firms. C. G. Power, Commons, *Debates*, 1939 (1st session), pp. 822-3.

[81] PAC, DCH Minutes, 29th meeting, 29 Nov. - 1 Dec. 1934, pp. 1-2.

[82] Commons, *Debates*, 1935, p. 1136.

[83] *Ibid.*, 1935, pp. 179-80.

[84] J. T. Sproule, *ibid.*, 1935, p. 165; J. P. Howden, *ibid.*, p. 1136.

[85] Alexander M. Young, *ibid.*, 1938, pp. 1979-80.

[86] Quoted by H. E. Spencer, *ibid.*, 1934, p. 500.

[87] Daniel McIvor, *ibid.*, 1939, p. 1573.

[88] "Medical Relief," editorial, *CPHJ*, XXV (Apr. 1934), 187.

[89] C. Howard Shillington, *The Road to Medicare in Canada* (Toronto: Del Graphics Publishing, 1972), preface.

[90] PAC, DCH Minutes, 27th meeting, 16-18 Oct. 1933, p. 23.

[91] Alexander M. Young, Commons, *Debates*, 1938, pp. 1979-80.

[92] For a sociological study of this problem, see Bernard R. Blishen, *Doctors and Doctrines. The Ideology of Medical Care in Canada* (Toronto: University of Toronto Press, 1969).

[93] R. D. Morand, Commons, *Debates*, 1935, p. 182.

[94] Humphrey Mitchell, Commons, *Debates*, 1935, p. 1081.

[95] "Medical Relief," p. 186.

[96] Gray, pp. 236-41.

[97] H. R. Fleming, Commons, *Debates*, 1938, pp. 1080-4.

[98] D. M. Sutherland, *ibid.*, 1935, p. 1137.

[99] R. J. Manion, *ibid.*, 1919, p. 1182.

[100] PAC, RG 29, vol. 858 (file 20-C-33, part 1) Letter from T. C. Routley of the CMA to Deputy Minister R. E. Wodehouse, 13 Feb. 1940.

[101] For a discussion of the hand the medical profession has in its own regulation in Canada and elsewhere see Malcolm G. Taylor, "The Role of the medical profession in the formulation and execution of public policy," *CJEPS*, XXVI (Feb. 1960), 108-27; G. R. Weller, "Health Care and Medicare Policy in Ontario," in *Issues in Canadian Public Policy*, ed. by G. Bruce Doern and V. Seymour Wilson (Toronto: Macmillan, 1974); Ivan Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (London: Marion Boyars, 1976).

[102] PAC, RG 29, vol. 861 (file 20-C-46, part 1) Correspondence between Canadian Red Cross and the Department, October 1919.

[103] PAC, DCH Minutes, 2nd meeting, 17-19 May 1920, pp. 5, 32 and p. 3 of Resolutions; 3rd meeting, 25-26 Oct. 1920, pp. 3, 24-30; 6th meeting, 13-15 June 1922, p. 2.

[104] *Ibid.*, 2nd meeting, 17-19 May 1920, pp. 6-9.

[105] In the late 1930s, the Deputy Minister of Pensions and National Health was also president of the CPHA. R. E. Wodehouse, "Presidential Address," *CPHJ*, XXX (Aug. 1939), 369-76.

[106] See, for example, Collins, pp. 54-5.

[107] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, pp. 18-24. RG 29, vol. 427 (file 580-1-3).

[108] PAC, DCH Minutes, 19th meeting, 18-20 Nov. 1929, p. 50.

[109] T. B. Windross, "More than One Thousand Lives Saved Annually by Alberta Health Services," Calgary *Herald*, 21 July 1934. Defries, *The Development of Public Health in Canada*, p. ix.

[110] PAC, RG 29, vol. 97 (file 156-2-4) Letter, C. M. Hincks, Director, to MacLaren, 24 Nov. 1932.

[111] William G. McQuarrie, Commons, *Debates*, 1929, pp. 1328-9. PAC, DCH Minutes, 18th meeting, 4-6 Dec. 1928, pp. 16-7.

[112] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, p. 3.

[113] R. B. Bennett, Commons, *Debates*, 1937, pp. 105-7.

[114] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, p. 25.

[115] PAC, RG 29, vol. 885 (file 20-R-3) Letter, Wodehouse to Dr. John A. Ferrell of the Rockefeller Foundation, 19 Dec. 1936.

[116] See debate, Commons, *Debates*, 1932, pp. 1817-21.

[117] PAC, DCH Minutes, 27th meeting, 16-18 Oct. 1933, n.p.

[118] *Ibid.*, 24th meeting, 28-31 May 1932, p. 1.

[119] PAC, RG 29, vol. 290 (file 408-5-2, part 1) and vol. 291 (file 408-5-2, parts 2 and 3).

[120] Pagé, p. 458.

[121] PAC, DCH Minutes, 32nd meeting, 15-16 June 1936, appendix.

[122] Heagerty, "Amendments to Canadian Maritime Quarantine Regulations," p. 228.

[123] "Important changes in Maritime Quarantine," editorial, *CPHJ*, XXVIII (May 1937), 243.

[124] PAC, DCH Minutes, 27th meeting, 16-18 Oct. 1933, p. 92.

[125] *Ibid.*, 20th meeting, 3-5 June 1930, pp. 1-2.

[126] Peter J. Veniot, Commons, *Debates*, 1932, p. 1817.

[127] PAC, DCH Minutes, 26th meeting, 13-15 June 1933, p. 3.

[128] *Report, PNH, 1932*, pp. 119-20; Murray MacLaren, Commons, *Debates*, 1932, p. 1817.

[129] Jeffs, p. 283.

[130] *Report, PNH, 1932*, pp. 106-10; *ibid., 1936*, p. 146.

[131] *Ibid., 1933*, p. 83.

[132] PAC, RG 29, vol. 19 (file 10-3-1, part 2) Memo, Heagerty to J. Anderson, chief accountant, 9 Nov. 1933.

[133] *Report, PNH, 1932*, p. 67.

[134] *Ibid., 1933*, p. 61.

[135] *Ibid., 1934*, p. 69.

[136] *Ibid., 1935*, p. 132.

[137] *Ibid., 1935*, p. 85.

[138] *Ibid., 1939*, pp. 95-8.

[139] PAC, RG 29, vol. 237 (file 335-2-2, part 1) and vol. 258 (file 347-1-6, parts 1 and 2).

[140] PAC, RG 29, vol. 260 (file 347-1-9, parts 1 and 2).

[141] These the Division distributed free to hospitals and other institutions. *Report, PNH, 1938*, p. 106.

[142] PAC, RG 29, vol. 260 (file 347-1-8) Correspondence between Glen F. Card and Heagerty, Jan.-Feb. 1939.

[143] C. G. Power, Commons, *Debates*, 1939 (1st session), pp. 331-2.

[144] *Report, PNH, 1934*, pp. 90-1.

[145] *Ibid., 1936*, p. 131.

[146] *Ibid., 1933*, p. 76.

[147] *Ibid., 1931*, p. 97.

[148] *Ibid., 1932*, p. 97.

[149] C.H.L. Sharman, "The New Narcotic Act," *CPHJ*, XX (Oct. 1929), 484-8.

[150] PAC, RG 29, vol. 604 (file 325-3-6).

[151] *Report, PNH, 1932*, p. 90.

[152] PAC, RG 29, vol. 539 (file 320-1-8, parts 1 and 2).

[153] *Report, PNH, 1931*, pp. 78-96.

[154] PAC, RG 29, vol. 233 (file 323-13-6, parts 1 and 2) and vol. 551 (file 320-5-7).

[155] PAC, RG 29, vol. 551 (file 320-6-5) Letter, Sharman to A. E. Blanco of Anti-Opium Information Bureau of Geneva, 28 June 1935.

[156] *Report, PNH, 1937*, p. 99.

[157] *Ibid., 1934*, p. 81.

[158] *Ibid., 1935*, p. 100 and *1936*, pp. 120-1.

[159] *Ibid., 1933*, p. 71. The other fear was that young people would become addicted to aspirin dissolved in coca cola. PAC, RG 29, vol. 602 (file 325-1-3) Letter, Sadie P. Morrison of the Women's Christian Temperance Union, Brantford to Sharman, 28 Sept. 1935.

[160] Whitaker, p. 68.

[161] *Report, PNH, 1939*, p. 109.

> Largely as a result of inexperience in meeting such economic pressure as is prevalent today, our whole medical profession, both in public health and in all the branches of therapeutic medicine, are [sic] as panicky as a man lost in a large swamp. They are hopping from hummock to hummock without any definite plan in mind. They are hoping to find a way out and in the meantime trying to locate a spot where the footing will be a little more secure.
> --W. J. Bell, Deputy Minister of Health for Ontario, in the *Canadian Public Health Journal*, July 1934.

Chapter Six

FROM HUMMOCK TO HUMMOCK

EMERGENCY MEDICAL CARE IN THE DEPRESSION

The Canadian health system was unprepared for a situation in which a vast number of Canadians could not pay for treatment. That the field of disease prevention had never attained its full stature is apparent from the division of funding. All levels of government spent annually by 1930, a total of about seventeen million dollars on prevention. At the same time, the total expenditure on treatment of illness was nearly $273,000,000. This great disparity was not due simply to choice but to confusion as to what constituted a better course of action. As a prominent official of the Department of Health explained, "it must not be forgotten that the great majority of illness is not really preventable."[1] As long as the economy was such that citizens could bear some of the cost of their own treatment, the system seemed to limp along. However, when this became no longer the case, the three levels of government were hard put to accept more responsibility, burdened as they already were with ordinary and extraordinary expenses. The Deputy Minister of Health for Ontario pointed out that the ensuing chaos was all that could be expected in the circumstances. In all the years of haggling and discussion, the parties responsible for health in Canada had failed to develop a rational, comprehensive strategy. The Depression caused a general breakdown and no segment of the health care network knew what to do about the emergency.

> When the recent economic crash occurred, it found the medical profession unprepared because no very general and intensive study had been given to the subject and the profession, generally, were without personal experience along this line. The government was even less prepared than the profession. The public was in a state of panic. Illness occurred as formerly but fees were not available for services rendered and the profession looked to the municipality on whose shoulder was placed the statutory duty of financing these requirements. The municipalities, many of whom are poor at the best of times, found themselves utterly unable to carry the load suddenly thrust upon them and a general appeal was made to the Provincial and Federal Governments.[2]

Although he felt that not just relief of symptoms but a general systemic overhaul was needed, this official also warned that it was a perilous time in which to make changes.

> Our experience of these trying times will be valuable but it certainly should not be taken as a basis for the development of a plan for the administration of a medical service. One is not justified in forming a plan to meet the normal or nearly normal on a basis that is so seriously abnormal.[3]

Most provincial health officials agreed and few moves were made. A book on Canada's welfare administration published in 1930 lamented that "no province has as yet accepted the genuinely democratic, modern program which makes public provision for the curative treatment of all the victims of a struggling civilization."[4] Another book on the same topic published fifteen years later insisted that the intervening Depression had not been a period which encouraged provincial administrators to take over such provision.

> Uncertain about long-run national policy, preoccupied with financial grievances against the Dominion, and handicapped by unbalanced budgets, the provincial authorities had but little disposition to build up their programmes constructively . . . Pending solution to the Dominion-provincial controversy the provinces tried to avoid making permanent commitments about the extent of responsibilities that they would assume.[5]

Fortunately, this long-term dispute over who should be doing what did not stop provinces and Dominion alike from doing something to try to alleviate the situation. At various times throughout the decade, various types of solutions were tried by various levels of government. Deportation of the sick and dependent and public education could only effect insignificant improvements as neither attacked the real problem of a large impoverished population needing everyday medical care. Subsidies from the medical profession, municipal doctor systems and health units would all have more effect. However, although any one of these might provide a little firmer hummock for a time, none solved the basic problem of how to get out of the swamp. Canadian health officials did not seriously address themselves to this problem until the last half of the Depression. By that time another call for reform, not unlike that accompanying the close of the Great War, was being raised. The federal Department would respond by changing old and adding new divisions and by starting negotiations to open the way for a comprehensive scheme of compulsory health insurance for the Canadian public.

In the early years of the Depression, attention to the state of health of the general population still centred around the venerable conviction that the major cause of poverty (through unemployment and under-employment) was ill health. This belief surfaced in the implementation of public policy in the practice of deporting hundreds of landed immigrants who had minor physical defects and who had ended up on the relief rolls. Their failure to obtain employment was blamed on their disabilities although it was also admitted that "[in] a number of cases the disability was so slight as to indicate that had these immigrants found conditions in Canada to their liking it would have been possible for them to earn their living in the general labour market."[6] There was no suggestion that these deportees might have no work simply because there was no work to be had. Rather, their unemployment was their own personal fault, due to the fact that they were either physically defective or just "malingerers."[7] By mid-decade, the perception of cause and effect was shifting. In 1935, the United States Committee on Economic Security released a report tempering the assertion to "in normal times from one-third to one-half of all dependency can be traced to the economic effects of illness."[8] The opinion of the Report was repeated by Grant Fleming, one of Canada's leading public health figures, before the Montreal Women's Club two years later.[9] And by 1940, when the Royal Commission on Dominion-Provincial Relations published its finding on public health in Canada, the shift was complete. While not arguing that the old belief "that people were poor because they were sick" had no validity, it was also true that "we find increasing evidence that they are also sick because they are poor."[10] Still, this did not let health agencies off the hook. Improvement of the nation's standard of health did not rest in simple solution of the unemployment problem. Health would no doubt experience some restoration with the return to happier economic circumstances but, in the meantime, the unemployed segment of the population might undergo permanent, or at least long-term, debilitation due to under-nourishment and lack of medical care.[11] But to win their case, reformers wishing to use this lever to force, if not reform, at least relief had to be able to show that it was indeed the case that the health of Canadians was suffering due to the economic Depression. This task was more difficult than might be expected.

For one thing, Canada went into the Depression with absolutely no idea of the extent of sickness already extant in the country. When asked to produce such data by the parliamentary committee on Industrial and International Relations, the Dominion Council of Health had trouble even coming up with a list of all the agencies whose records might be tapped in order to compile some reasonably accurate figures.[12] As late as 1936, the DCH passed a motion asking that the Dominion Bureau of Statistics collect morbidity statistics from the provincial health departments and prepare a national morbidity code.[13] Better collection of statistics would not have solved all informational problems. Morbidity rates were compiled partly on the basis of who sought medical attention and, due to inability to pay, it was probable that fewer sick sought professional help than before the Depression, therefore making any comparison inaccurate.[14] The other choice was to extrapolate from the mortality rates but this was not very satisfactory either. The use of a set of statistics--collected only to indicate the number of deaths--in an attempt to answer a related but separate question--the amount of sickness--was fraught with many complications.[15] Besides, according to the records, the death rate had been dropping steadily for years and would continue to do so throughout the Depression.[16] Impressions at the start of the period were that unemployment seemed to be causing no serious deterioration in health among those affected.[17] Evidence to the contrary started surfacing soon thereafter but it was scattered and impressional.[18] It was not until Leonard Marsh's study *Health and Unemployment* was released in 1938 that anything approaching a definitive answer could be given to the question of how unemployment and health were connected. Using demographic methods that today seem simplistic, Marsh however did come to the conclusion that, yes, unemployment lowered the standard of health not only of the wage-earner but of his dependents, despite relief provisions.[19]

However, the most unsettling thing that Marsh's and others' studies had to show was that a theory of natural selection could not be applied.[20] There was no reason to believe that the fittest--the healthy, educated and socially acceptable--were holding on to their jobs and some semblance of prosperity while the unfit were gravitating towards the bottom of the heap.

> While a good proportion of the dependent group is no doubt made up of people of the least efficient type, there is abundant evidence that a great many who are essentially sturdy, self-reliant citizens of good quality are now on the relief rolls. *Dependency has ceased to be a monopoly of the lowest social and economic groups in the community.*[21]

Even worse, the "new poor" as they were dubbed seemed to suffer more than the old poor. For one thing, they were reluctant to apply for relief, meaning that by the time they did so they were often in really dire straits[22] and, for another, they had less experience at being impoverished and could not make relief payments stretch as far.[23] A study in the United States revealed that people who fell from comfortable circumstances in 1926 to poor in 1936 suffered more sickness than people who had simply remained poor throughout that decade or fallen from less of a height.[24] This finding was borne out in Canada. A study of nutrition standards among Montreal unemployed men showed that 41.9 percent of former white collar workers had a good nutrition rating compared to 61.9 percent of former unskilled laborers.[25] It was also feared that the middle class was at a similar disadvantage when it came to medical care. The wealthy could pay for anything they wanted; the poor had no shame when it came to asking for available free service. This left those who had always had to make and who had always been proud of making their own way in life.

> The class of people who are [sic] suffering most under our system of medicine are the so-called poorer middle class, those who cannot and do not and will not accept free treatment, who do not wish to be classed as charitable and indigent cases, who are endeavouring and will endeavour, in some way or other, to pay their way in the world.[26]

It was feared that poor health standards and employment handicaps among these people would "breed a new generation" of naturally dependent individuals "unless counteracting forces are put into operation."[27] Immediate relief and, more importantly, a long-term program were needed to counteract irreparable damage to the future prospects of Canada.[28]

In short, it was agreed that something must be done but agreement as to who was to do it was another matter. Certain types of health breakdowns could be traced directly to the adverse effects of the Depression. Transients mutilated in attempts to board freight cars[29] and federal work relief crews sickened with arsenic as a result of being billeted in a curling rink used for mixing poison bait for grasshoppers[30] were problems that had not existed under other circumstances.

Jurisdictional disputes over these types of problems were the easiest to solve. Unemployed males who made their way to federal work camps, also seen as direct casualties of the economic conditions, again were taken care of fairly easily, the Dominion shouldering the load.[31] The really difficult negotiations came in dealing with the old problems which may have worsened due to the Depression but were old problems nonetheless. These, all authorities were chary about accepting as their own. Illness directly linked to the Depression could be expected to exit with the advent of prosperity--or at least within a reasonable time thereafter. But stepping in now to bring grossly inadequate health provisions up to the slightly more adequate standards that had existed pre-Depression could lead to long-lasting ownership of an unwanted and expensive responsibility. Aversion to doing so was not simply a matter of irresponsibility. There was a basic reason why Canadian municipalities and provinces did not rush in to safeguard the health of their people--they had neither the money nor the tax base to raise more. Under the circumstances they did all they could: provided what they could afford, begged more from the federal government and left the rest to the medical profession and voluntary agencies.

It must be remembered that even though medical care is desirable and often absolutely necessary, it is not usually as immediate a need as food and shelter and even, perhaps, clothing. For this reason, expenditures on health were not only not increased to meet the new emergencies, they were cut back. In an atmosphere where those on relief were not even being provided by the public purse with enough food to maintain a sound nutritional level,[32] it is not surprising that some of the first serious government cuts came in the field of health care.[33] This false economy was deplored by some. Angus McInnis rose in the House to call attention to shortfalls in medical care forced upon his own constituency.

> The city of Vancouver has been able to care for its unemployed without further borrowing but it has done so at the expense of the present and future health of the children of the city.[34]

The fact was that municipalities, upon whom relief of the indigent devolved,[35] had more problems than they could handle just trying to provide the basic necessities of life. In some municipalities, unemployment relief included absolutely no provision for medical care or, indeed, clothing.[36] Others tried their best to keep up with the situation, at least during the first days of crisis. Regina provided medical attention, dental and optical service, drugs and other medical assistance if required.[37] However, other municipalities found it impossible to bear the strain. A study made early in the Depression outlined a worsening situation typical of many Ontario municipalities.

> Everywhere there are reports that the depression has made for greatly increased pressure upon the free medical services. Practically all of the medical officers who were consulted commented upon the fact that the amount of unpaid medical services had grown enormously during the depression. Municipalities find that their hospital bills for indigent patients have mounted a great deal. There have been substantial increases in the number of free visits made by the public health nurses of such organizations as the Victorian Order of Nurses. Hospitals which have out-patient departments report that attendance at these departments (which usually make a nominal charge or no charge at all) has increased immensely, in some cases being two or three times as great in 1931 as it had been in 1928 or 1929. At the same time, the number of paying patients in many hospitals has decreased, so that in general hospital revenues have fallen off sharply at the very time when they are called upon to render more service to non-paying patients. For some of them, this has created an acute financial problem. Practising physicians have been caught in a situation of the same kind.[38]

An additional problem was that some convalescent cases could not be released from hospital because they had no place to go.[39] Smaller municipalities could not bear up under the stress. In some cases, larger urban centres helped them out[40] but in general, it was the provinces that were turned to in this time of trouble.

For the most part, the provinces accepted as much extra responsibility for health care as they could. Some, like Ontario, bailed out bankrupt municipalities as best they could;[41] others, like New Brunswick, had no system of municipal health and were forced to handle the increased call for care directly.[42] Quebec had somehow to provide care in the infant settlements that had sprung up in the north as part of the back-to-the-land movement.[43] But the provinces could not do what was expected of them in provision of immediate health care[44] without cutting back on some of the public health measures they had managed to introduce in the 1920s.[45] Ontario estimated in 1938 that ninety-three percent of its health budget went to support hospitals and sanatoria and to treat diphtheria, scarlet fever, tetanus, cerebrospinal meningitis, poliomyelitis, venereal disease, diabetes and cancer. It was now being asked to add pneumonia to the list. As a report to the DCH summed matters up: "Frankly, the therapeutic aspect of the public health programme is swamping the prophylactic."[46] As if they had not enough problems, the provinces also had to deal with another termed the "transient sick." The difficulty of a sick person moving from one health jurisdiction to another was not a new one. British Columbia had for years provided care for invalids from other provinces come in search of milder climes. Cities like Sudbury found men from northern lumber camps appearing on their sick rolls.[47] But while a blind eye may have been turned to a reasonable number of such cases in times of prosperity, this was not so in times of adversity. By mid-Depression, things became so tight that the DCH held a discussion to decide to which municipality the care of a person infected with a communicable disease should be charged: to the place the disease was diagnosed, to that where it was contracted or to the sufferer's usual place of residence.[48] The decision was that it should be treated where diagnosed, at the expense of that municipality.[49] This decision does not demonstrate any real humanitarianism. It rather was taken for a very practical reason. The disease most feared in this matter was tuberculosis. In certain cases and at certain stages, TB can be virulently infectious. Loading a sufferer onto a train to be sent back home was not a way to halt the spread of disease throughout the country.[50] Responsibility for the care and segregation of such people supposedly lay with the common carrier but these did not always fulfill their obligations.[51] Many of these people arrived back in a municipality they might not have seen for years. The local medical health officer was often totally unaware of the entry of this carrier of a serious disease into the community. Even a system of notification among health officers[52] could not solve all problems. Some invalids had been living in new areas quite some time and were surrounded by family and friends. Sending them back to where they might no longer have anyone to care for them worked great hardships and patients frequently objected strenuously not just to being moved to another province, but even to another community.[53] However, the decision that sickness must be treated where it was found discriminated against provinces such as Manitoba. This province provided free hospital care for all sick within its borders; people went there from western Ontario and eastern Saskatchewan to reveal their illness.[54] By 1938, the western provinces had worked out a reciprocal arrangement to avoid such gross inequities.[55]

But there were two related problems that the provinces could not work out and the Department was involved in both of these. One involved inmates released from federal penitentiaries. If these people broke down physically or mentally within six months of release, the Dominion was held responsible for their care. After six months, whatever province the ex-prisoner had settled in had to provide. The provinces felt the grace period was too short and asked that it be extended.[56] The other problem involved deportees. The provinces were not happy about having to care for persons slated for deportation while the Dominion machinery readied itself to effect the ouster.[57] But this was the easy part. The hard part was providing for Canadians deported from other countries. This was not a new problem. Complaints were raised in the mid-1920s about having to accept back sick persons who had long been residents of the United States.[58] With the start of the Depression, many more cases--usually afflicted with tuberculosis or mental illness--were hurried north over the border. The Dominion did not object as it was likewise hurrying United States nationals south as fast as it could.[59] The city of Windsor, however, objected as it was the port through which most Canadians were repatriated. Many no longer had homes in Canada and simply stayed in the area, becoming charges on the local relief rolls. The medical health officer for the Essex Border Municipalities started a campaign of complaint about this state of affairs in 1933. Alarmed at the repatriation of a woman with a criminal record and a pulmonary hemmorhage, now being cared for in Grace Hospital, Windsor, Dr. F. Adams wrote the Department in mock puzzlement.

> As I understand our Ontario and Dominion laws there is no provision for the care of such cases. Apparently the United States authorities can land a major infectious disease in my municipalities without my consent or information and apparently the Dominion Authorities think that is all right. I am unable to understand why I have any duty in the matter at all. I am unable to understand why Grace Hospital has any duty, and I am unable to understand why Grace Hospital should be uncertain as to who is going to pay them [sic] for the patient's hospital care. I am unable to understand also why the City of Windsor and its citizens should be endangered by cases of this kind and why they should be involved in a possible financial loss in connection with her.[60]

Heagerty checked matters out with the Department of Justice and informed Adams that unless the case involved quarantine, it was solely within the provincial reserve. Not only that, it was the problem of the municipality and province in which the deportee landed--costs could not be charged against another municipality or province, even a known place of birth. Neither could costs be spread out over all provinces to make matters fairer. Informed of this state of affairs, Adams' next tactic was to pack a repatriated Canadian citizen, formerly from Italy and resident in the United States for nearly a decade, off to Ottawa with a note for Heagerty in his pocket. The man was suffering from bilateral far-advanced pulmonary tuberculosis. Heagerty sent him over to the Deputy Minister of Immigration, another letter in hand. That official found out that the man had given false evidence when he entered the United States in 1925, warned him that no action would be taken against him this time and released him into the community.[61] When informed of this train of events, Adams, while obviously at his wits' end as to how to get help in caring for such persons and relieved at having at least this one off his hands, was appalled at this cavalier attitude towards carriers of a grossly-infectious disease.

> The final result of the above system of passing the "buck" is that open cases of tuberculosis wander about the country, presumably infecting large numbers of persons, simply because no authority will take responsibility for their care. I don't think anyone can question the statement that this is an exceedingly bad way to handle a major infectious disease. . . . The present system of handling these cases, (or the system of failing to handle them) is inhuman, bad public health, and a public scandal.[62]

A committee was established in early 1936 to work up some sort of reciprocal agreement acceptable to all provinces in regard to care of all transients. Although it made some headway in the matter of interprovincial transients,[63] it did not solve the problem of deportees. By 1938 the general practice was to return them to the province of their birth[64] but this carried no guarantee that they would receive treatment there. In the last year of the Depression, Quebec insisted that it would only accept for treatment deportees who had parents who would cover the costs of hospitalization or whose old municipality would make a similar pledge. As for any others, "[if] the Immigration Department accepts repatriation, the Federal Government must needs obviously assume the cost of internment."[65]

The truth was that the provinces were finding care of people they acknowledged as their own citizenry in good standing overwhelming enough without taking on special cases. Much of the work left undone by the provinces and the municipalities was taken over by the medical profession. Treatment was still considered very much the preserve of doctors and no government liked to interfere.[66] This led to a situation where a government or another body might pay for diagnosis of a defect then send the sufferer off to a doctor whom he or she might not be able to pay.[67] Despite the fact that the governments were not only allowing, but sometimes actually asking, the profession to take on increased burdens after the Depression hit,[68] there were at first no moves to recompense doctors for this public service.[69] Even after some provision was made to pay the bills of those on relief, indigents who had never applied for or who had been denied relief still had to be cared for, usually at the expense of the profession.[70] This situation was by no means peculiar to Canadian doctors. In order to maintain some sort of living, United States physicians resorted to lowering fees, spreading costs over a longer time by granting credit or adopting an insurance principle.[71] In an attempt to drum up some paying business for its members, the Canadian Medical Association administered a periodic medical examination scheme for four major life insurance companies.[72] Doctors were paid four dollars an examination and clients could choose any doctor they wished among the whole CMA. That not all medical men were suffering alike from reduced circumstances was soon demonstrated when some members objected to selling time and skills for four dollars for which they could get fifteen to twenty-five dollars.[73] The CMA pulled out of the scheme after only one year and turned the work over to the Canadian Medical Institute,[74] newly constituted, one would suppose, from the needier physicians.[75] Indeed, the reaction by members of the medical profession to the Depression was as varied as that of any other group of people. While some gave of themselves freely, others refused to attend even women in labor if not paid beforehand.[76] That people would be shocked when doctors refused to travel as far as twenty miles[77] just for the pleasure of giving free service had to do with the mystique that the profession had enjoyed and encouraged. It would not be long before it was willing to abandon some of the mystique for a living wage.

When the doctors failed, there were still the voluntary agencies.

While not all service by the agencies was as well-publicized as that of the Canadian Council on Child and Family Welfare,[78] many did yeoman work. One health official stressed that "[never] since the war have our people undertaken to do so much, voluntarily, for a social cause."[79] But agencies such as the Victorian Order of Nurses and the Red Cross also felt the economic pinch. Due to lack of funds they could only treat the completely indigent or extremely ill.[80] Most underwent a cut of ten percent in their federal grants early in the Depression[81] and were threatened more than once with discontinuance of the money altogether as the federal government considered channelling all available funds to the provinces.[82] But the federal government could hardly pull the rug out from under those who were providing necessary service, especially with demands that it enter the ring itself reaching such a pitch. These proposals took several forms: that the federal government provide directly examination and treatment of all the Canadian population;[83] that it allot extra moneys for medical care in the relief funds it designated for the provinces;[84] that it take over the work of the various voluntary agencies.[85] All were big undertakings and the provinces could not just sit back while the Dominion came to terms with the extent of commitment it was willing to make. Thus, while in June 1933 the DCH would pass a motion calling for increased help from that quarter[86] at its very next meeting it would discuss how to keep afloat in the meantime.[87] The topic would be unearthed at intervals throughout the Depression.[88] In the end, all provinces did manage medical relief to some extent and some would concoct schemes meant for long-range rationalization of health service. The two western-most, British Columbia and Alberta, would pass health insurance acts that would never come to fruition but which were portents of the plan the federal government would finally settle on at the end of the decade. In the interim, the Department tried to ameliorate the situation by taking part in deportation and public education, by providing the provincial governments with some emergency funds and in the late 1930s by adding new Divisions designed to take on previously neglected health problems. Although its attempt to come up with a scheme designed to ensure long-term tranquillity and efficiency in Canada's health care delivery system had to wait until after World War II for introduction, by the end of the 1930s the federal government had taken over much more in the funding of health care than it had ever previously admitted its responsibility under the BNA Act.[89]

The federal schemes of deportation and public education were early responses to the emergency situation. It was hoped that both would obviate the necessity for medical relief--the first by getting rid of some of the sick, the second by teaching the remaining population how to avoid sickness. The inefficiency of deportation was soon apparent. During the first full year of Depression, 928 persons were deported for reason of combined illness and indigence.[90] Perhaps due to a certain amount of outrage expressed over this process--J. S. Woodsworth rose in the House to object to deportation on humanitarian grounds[91]--the Department report of the next year carried full explanation of the philosophy and procedures. That year 840 were deported for becoming public charges due to mental or physical defects which existed prior to admission or developed within five years of arrival. Among the conditions serving as grounds for deportation were cancer, anemia, varicose veins, diabetes, colitis, ulcers, hernia, gonorrhea, syphilis, goitre, demonstrated suicidal tendencies, gall stones, malaria, alcoholism, epilepsy, Parkinson's disease, amputation, carious teeth, gunshot wounds, prolapse of the uterus, abscess of the breasts, senility, sinusitis, sunstroke, tonsillitis, mastoid disease, arthritis, tuberculosis, asthma, skin disease, pregnancy and, vaguely, "ill health."[92] The next year, deportations were down to ninety-two[93] and the number generally stayed considerably below one hundred throughout the Depression except for a high of 253 in 1934.[94] It is possible that the exile of these unfortunate people saved the nation some money, although it certainly must have cost something to round them up and send them off. It is even possible that some other Canadians may have been spared infection by the removal of these people from their midst, although the great majority did not suffer from communicable diseases. But it is not possible that the deportations could have had any significant effect on the standard of health in this country. It was not possible to find legal grounds to deport all those who were in need of help.

Public education was certainly a more humane, and probably a more useful measure. The Department had always put too much faith in the value of available information[95] but the difficult situation many people found themselves in perhaps made them more amenable to the assimilation of any hints that might pull them through. Most of the information passed on had to do with nutrition. Reduced circumstances meant that, if people bought the same quality of food as had always been bought, some cut must be taken in quantity. Better budgeting might solve part of the problem[96] but, in the long run, people were simply going to have to shift to cheaper foodstuffs. Barriers to this were seen as the general laziness of women, reluctant to expend energy in excess of that needed to open commercially canned food, a relatively expensive product,[97] and inexperience with the different cooking techniques needed to render edible the cheaper cuts of meat and substitutes such as legumes.[98] Propaganda campaigns were started to dispel sloth and ignorance. An annual National Health Week was proposed in 1933[99] and later in the decade there was talk of fielding three separate travelling exhibits (one each for francophones, anglophones east of the Great Lakes and anglophones in the west) to purvey health education.[100] But by far the most convenient vehicle for information was that new and intriguing medium, the radio. The Department and the Canadian Broadcasting Corporation originally got together in 1932 when the latter asked the former to censor all radio advertising re food and medicinals.[101] The relationship continued quite happily for several years.[102] When budget cuts led the Department to look for an alternative to the expensive publication of pamphlets, it decided to look into the use of short radio blurbs.[103] By 1938, fifty-seven Canadian radio stations carried daily National Health Bulletins.[104] However, there were basic problems with so democratic an approach to the release of health information. It was feared that too much detail about disease and its treatment was a dangerous commodity for the general population to have first-hand access to.[105] Some things were better heard from a doctor than a broadcaster. Another major drawback was that there were certain segments of the population who should not hear certain types of information at all and there was no way of screening listeners. For this reason, while the Department wanted more sex propaganda printed and distributed to parents who would then teach their children,[106] it did not want information for "women of child-bearing age" broadcast over the air-waves.[107] A related problem was the fact that some health information was considered by its very nature to be just plain offensive. In short, the CBC "is not going to let any objectionable venereal disease talk get into the drawing rooms."[108] The Department not only wrestled with the problem of making its own copy acceptable[109] but asked for and received power of censorship over any information prepared by any health organization for release into Canadian drawing rooms.[110] The long defunct Division of Publicity was reinstituted in early 1938 to take over this fast-growing aspect of Department work.[111]

Neither deportation nor public education in any way led the federal government out of its perceived roles--the latter activity had long been accepted as its obligation and the former was simply a variation on the old quarantine theme. Basically, throughout the Depression, although the Dominion helped out with emergency funds and Parliament spent considerable time debating attempts at innovative measures such as an abortive Hospital Sweepstakes scheme,[112] the provinces were left to themselves to come up with and administer measures for short-term and possibly even long-term medical aid. Despite all efforts, all such schemes were distinguished, according to Leonard Marsh, by two outstanding features. One was that provision of medical facilities was unequal. The other was that they were late in coming.[113] Relief measures had come earliest on the prairies due to the drought but British Columbia and the east did not get organized until mid-decade. When they did come on stream, most emergency relief schemes survived by use and even abuse of all organized health bodies in the province--the provincial health department itself; municipal clinics and hospitals; the medical, dental and nursing professions; medical faculties in universities; and voluntary agencies. Some of these received no reimbursement, others little. Some of the relief was not even truly organized--individuals and groups simply succored those who came to them.[114] This method was inefficient and it was unfair but in the face of hugely increased demand it was all that the disorganized system of health care in Canada could deliver. But while it may have provided temporarily safe hummocks, it was no way to get out of the swamp. Commendably, the Canadian provinces did not just sit back and abandon themselves to the changing economic tides. Several actively searched for new directions in health provision that would lead the way to security. Solutions put forward were subsidized health units, subsidized public and private medical care, and health insurance. Although the first three were actually put in functioning order by various provinces, it was the last measure--a failed attempt in both British Columbia and Alberta--that the Dominion would finally settle upon as the one to be encouraged and financially supported.

Health units were hardly a new topic of conversation in Canadian medical circles. The 1920s had seen a long struggle to see these established on a comprehensive basis. Many were established, mostly in the province of Quebec, seed money coming from the Rockefeller Foundation. Proposals for expansion of the system would be discussed frequently throughout the Depression but due to the federal government's reluctance to provide funds the struggle would instead centre around simple maintenance of the ones already functioning. Defined as a "miniature health department," a health unit operated in one or more counties, in parts of a county or in a designated district. Staffed by one or more full-time health officials, health inspectors and nurses, the unit functioned for the purpose of educating the public, attending to the well-being of children, preventing contagious diseases, and providing vaccinations and free laboratory diagnostic services.[115] Calls for such clinics started in the early 1920s, their establishment being seen as a way to replace the current system of part-time appointees, often with no public health training, with properly trained full-time health officers.[116]

Voiced objections centred around the conviction that these units would operate to the detriment of the medical profession. Indeed, the profession would continue to fight the establishment of this type of clinic for years, although Canadian dentists welcomed their establishment and easily adapted to working within their confines.[117] Doctors' opposition, however, did not seem to lead to a decrease in demand for this type of organization.[118] In 1927, the United Farmers of Saskatchewan asked that if some sort of permanent memorial were going to be established in honor of this, Canada's jubilee year, that it be a system of travelling diagnostic clinics for outlying areas.[119] This request led to a lively discussion in the Dominion Council of Health. Diagnosis without treatment was considered not only futile but dangerous--providing a sufferer with knowledge of a condition without making available the chance for treatment was seen as a sure way to cause neurosis. The obvious solution was to provide the treatment, too, but if this were done by the clinics that would undermine the profession. At the same time, sufferers in outlying areas had no members of the profession available to turn to.[120] The DCH's solution was to notify the Canadian Medical Association of this unsatisfactory state of affairs in order that it might work towards "the removal of the sources of complaint."[121] The CMA decided that such measures were the wave of the future and that doctors must prepare themselves for more state subsidization. The profession would even reap some advantage as previously unpaid charity work would now have some fee attached to it. The association was not optimistic, however, that many of its individual members would see things this way. The United Farmers association in its turn tried to get around such objections by establishing a committee to examine the feasibility of free clinics. The committee was composed of representatives of the medical association, the college of surgeons, and the hospital association as well as those representing the urban and rural municipalities and the United Farmers.[122]

It began to look like doctors were simply going to have to adjust. Despite doubts about the vigor of some,[123] most units already established under the auspices of the Rockefeller Foundation were doing Trojan duty.[124] The biggest bar to further progress was, as usual, lack of money. Rockefeller money was granted for only three years, after which the provinces had to find another source to cover the one-third of costs paid by the Foundation. Furthermore, only provinces with medical schools were eligible therefore completely disqualifying Prince Edward Island and New Brunswick.[125] While participating provinces hoped that Rockefeller could be talked into extensions, they stated their preference for replacement funds from the federal government--only they must be guaranteed for a reasonable period, not constantly threatened as were the VD grants.[126] The Department of Health had already tried and failed to obtain $100,000 for this purpose[127] when the DCH passed a resolution at the end of 1928 claiming health units as the hope for the future of Canada's health, regretting the lack of funds for them at both the municipal and provincial levels and asking the federal government to live up to its responsibilities as "under the British North America Act it would appear that control of the administration of health work is left to the jurisdiction of the Dominion Government."[128] The federal government, as usual, was not willing to accept this interpretation of the BNA Act. While expressing support for health units, the Minister of Pensions and National Health stated firmly that they were a provincial concern and that the Department had no intention of funding them now or in the near future. At the end of this firm statement came a quibble, in the nature of a promise that he was always open to a change of mind,[129] that was destined to keep hopes alive. The DCH at first resigned itself to failure after this speech,[130] its hopes not responding immediately to a motion agreed to in the House of Commons in March 1930 that "the government should take into consideration the advisability of making grants to the provinces equal to one-third the cost of establishing, and to cover permanently such full time health units as may be organized."[131] It was still considered unlikely that funds would be forthcoming because "the provinces had more money than the Dominion."[132] However, by the end of that year another government was in power, comprised of the party that had forced the above resolution. Hopes picked up in the DCH to the extent that it started pressing for more than the three years of funding it felt it had reason to expect.[133] But when the matter was resurrected in the House in the spring of 1931, things did not look so certain. The new Conservative government promised only to consider making grants.[134] A conference was called to discuss the matter[135] and the DCH felt sure that this time they had Prime Minister R. B. Bennett over the barrel because he, "while the Liberals were in power, made good strong representations that they should help Health Units, and of course they tied him to it, and he had to say he agreed to it."[136] Nothing came of the conference or the promises. British Columbia, which had been the first province to open such a unit in 1927, managed to hang onto its three throughout the Depression. Alberta and Manitoba, which had both opened their first in 1930, also maintained their three each. Ontario ran its sole unit and Nova Scotia opened one by the end of the Depression. New Brunswick and Prince Edward Island never got a chance to participate. The big convert to this type of health organization was Quebec which had twenty-three units by 1933, fought hard to keep these and expanded to thirty-eight by the end of World War II.[137] By 1938, the provinces were still asking for help in this area.[139] But by this time, the Department clearly understood that it would have none to give. Not only could it not assume the costs taken on by Mr. Rockefeller in the aid of other jurisdictions, it wanted to lay its hands on some itself: "We, as a Dominion Department, could bury our pride sufficiently to accept money, if we could get it from him."[140]

The municipal doctor system was different from a network of health units in that a municipality retained a doctor to act as public health officer with all the usual work of education and disease prevention but also as a sort of private practitioner working under subsidy. Although tried in all the prairie provinces,[141] the system was used most extensively in Saskatchewan. The municipal doctor scheme pre-dated the Depression in this province but it was extended during that decade. Saskatchewan had early to deal with relief, especially in the drought areas. As doctors in these municipalities saw their incomes dwindle to practically nil and as municipalities faced the prospect of losing their only doctor, both parties would sign a contract.[142] After approval by three-fifths of the resident rate-payers, taxes would be raised in order to guarantee the doctor a salary of between $3250 and $4500 per annum for three years. For this amount he would undertake to supply all medical care needed in the community. He was allowed to supplement this income through such things as dental work and insurance exams.[143] Although there was controversy over this system of "state medicine,"[144] it weathered the hard times[145] and by mid-decade existed in sixty-six Saskatchewan municipalities accounting for about thirty percent of the rural population.[146] But, although there was agitation to extend the system even further, hopefully covering the whole province,[147] there were some municipalities that could not possibly afford to pay for such services. To these, the province granted relief of seventy-five dollars and twenty-five dollars a month respectively for physicians and dentists. In addition, hospitals received twenty-five cents per day per relief patient.[148] By well into World War II, the municipal doctor system covered only 103 of Saskatchewan's 343 municipalities.[149] It was a good try but it had not managed to provide comprehensive health care to the whole population.

Ontario also tried a system of subsidization for the medical profession but this was carefully constructed to avoid any suggestion that doctors had fallen to the status of wage-earners. Since 1932, Ontario had provided some unemployment medical relief to be administered by various municipalities. However, by 1935, the system had proven so inefficient that the province threatened to pull out and force separate municipalities to make their own arrangements with separate doctors unless the medical profession was prepared to undertake provincial administration of a new scheme.[150] As with the old method originally introduced in November 1932, members of the profession would submit bills at full tariff rate with the understanding that they would accept half as payment, "the unpaid remainder to be considered as a contribution of the medical profession to meet the existing emergency."[151] Although the money was the same, the distinction was important. The philosophy of the medical profession allowed plenty of room for charity but little for working for wages--and cut wages at that. Under the 1935 scheme, rather than doctors receiving money directly from the province, a monthly grant was signed over by the government to the Ontario Medical Association [hereinafter OMA]. Doctors would submit all bills to their own association and receive in return payment in proportion to the amount of work they claimed and the size of the grant for that month.[152] Although this appeared to some health commentators as the ideal situation,[153] such a plan having previously been suggested for the whole country,[154] the OMA had deep reservations about involving itself so intimately with the state. Still, its council voted eighty-nine to three in favor of giving it a try. This decision had been encouraged by beliefs that "[working] together, we can gain much experience and knowledge which may prove invaluable in the days to come" and that the association could maintain enough control for its own safe-guarding.[155] But it was just this control that in the end would render any such scheme unsatisfactory in the long run. As Leonard Marsh pointed out, the control of public funds by a professional association, even though highly reputable, constituted "a defection from democratic principle which should not be lightly disregarded or glossed over."[156] The public health services were not even represented in the administration of the grant and as the Deputy Minister of Health for Ontario pointed out before the system ever got off the ground, any scheme administered by medical men with no public health training was destined to be long on cure and short on prevention.[157] Therefore, while it might do in an emergency, it held no hopes for comprehensive health care for Canada.

But there was one scheme proposed during the Depression that did seem to hold out hope. This was health insurance. Considered for legislation by British Columbia, Alberta, Manitoba and Quebec,[158] health insurance was actually passed into law in the first two. This was not the first time around for British Columbia. It had started investigating health insurance as a possible solution to the problem of promoting comprehensive medical care immediately after the Great War.[159] A resolution had been introduced in the provincial assembly in 1920 after which the government appointed a commission to assess the applicability of the health insurance schemes of other countries to British Columbia and to study voter support. This commission presented its report in March 1921, recommending that health insurance be made available for all wage-earners making less than three thousand dollars per annum. The report was approved at the next session but shelved, declared a federal responsibility.[160] A second commission was appointed in March 1928 to re-assess the situation.[161] Its report released in 1932 indicated overwhelming public support for health insurance and it became one of the leading issues in the 1933 election campaign. In 1935, a draft bill was drawn up, providing for compulsory insurance for all wage-earners earning less than $1800 a year. Except for an organizational grant of $50,000 from the provincial government, the scheme was expected to operate on its own income. In addition to doctors' care it provided for drugs, lab services, nursing care, some dental services and hospital treatment. There were also to be some cash benefits provided to replace income lost during illness.[162] Adverse reaction to the proposal was immediate. Business and industrial groups said they could not bear the one percent levy expected from them.[163] A petition was circulated claiming that health insurance was a "class measure instituted . . . [to] confiscate the earnings of industrial classes for medical incomes."[164] Insurance experts declared it actuarially unsound.[165] And despite earlier assurances from the provincial Deputy Minister of Health that the medical profession had been convinced such a program was in its own best interests,[166] this group complained that the indigent--the segment of the population to which free service had most often to be provided--were not covered and presumably would still call upon doctors' charity.[167] Provincial health officials declared that they intended to carry on despite all opposition.[168] The Minister of Health, G. M. Weir, made a stirring defence over the radio.[169] The government suspended application of the scheme but made it the subject of a plebiscite to be held in conjunction with the provincial election of 1 June 1937.[170] The plebiscite recorded a significant majority and with the return of the government it was assumed that health insurance would be gone ahead with.[171] Instead, no action was taken and the commission disbanded. Public health reformers were disappointed, not least of all because British Columbia had thrown away its chance to be the first legislative jurisdiction in North America to start state health insurance.[172]

Alberta had likewise been considering the introduction of a health insurance plan for quite some time. A prototype had been introduced at the 1919 convention of the United Farmers of Alberta.[173] It was that party that introduced the scheme while in power in the 1930s. A Legislative Commission presented its final report before the legislature during the 1934 session.[174] It borrowed heavily from the British Columbia plan and was immediately prey to the same criticisms.[175] Despite opposition, Alberta became, in 1935, the first province in Canada to place health insurance measures on the statute books.[176] However, Alberta changed governments almost immediately after the passing of this legislation and nothing came of it. In 1937, the Deputy Minister of Health for Alberta indicated that there would soon be a five year try-out of the scheme in two small areas[177] but not even this took place. Although neither provincial health insurance scheme was ever put into practice, the effort put into them had not been without value. The federal Department had taken great interest in the proceedings. In 1930, it asked for a copy of the 2500 page report prepared by the British Columbia Commission[178] and health insurance was frequently discussed during the first half of the 1930s, at federal instigation, in the Dominion Council of Health.[179] During the second half of the decade, Department interest became more acute. This interest was only one of the ways in which the Department demonstrated that it was beginning to take cognizance of the demands of provinces, politicians and reformers that it do something concrete to alleviate the unsatisfactory situation of Canadian health care.

The Department had never been very happy with the lessened stature forced upon it by government cut-backs during the early part of the Depression. In 1937, the chief spokesman for the Department lamented that "[the] National Health Section of the Department is not a department of health in the generally accepted sense of the term but comprises a number of public health services which are national in character."[180] And it did not even handle all public health services which were national in character. Throughout the decade, the Department tried to add the health of Indians in Canada in general and of all people residing in the Yukon and Northwest Territories to its responsibilities.[181] Nothing came of this. Neither did anything come of hopes for a Health Cabinet for Canada, to be comprised of all provincial ministers of health and provided with "Dominion leadership in health matters, with a co-ordinated health program for the Dominion."[182] As always, there seemed to be insurmountable obstacles in the way of direct Dominion action in health matters and by 1937, another tack was taken. Really this was just the same old tack, taken on with new vigor. In January 1937, it was proposed before the House of Commons that several divisions be added to the Department's roster. The Minister of Pensions and National Health, C. G. Power, pleaded the case:

> I hope the committee will give us an opportunity of bringing back this Department to the status which it was originally intended to have, that of the leading Department of Health in the Dominion of Canada. At the present time, owing to financial circumstances, the depression and one thing and another, the Department of Health is simply, if I may speak in military terms, a skeleton corps, and if we are to do something that will be of benefit to the country as a whole I think the department should be strengthened.[183]

This new initiative sprung from a conference of health ministers and deputy ministers held in the summer of 1936 at which no decision could be reached as to any health plan the Dominion might introduce that would be of equal interest to all provinces. Instead, each province asked for a straight grant so as to pursue its own studies. Power objected to this and decided it was better to put any money straight into the Department. It could then increase its collection and dissemination of information and the provinces could act on whatever they wanted.[184] It was the old publicity and information technique that had already failed in the 1920s. The headings under which this new information was to be collected and disseminated were Medical Investigation, Child and Maternal Hygiene, Nutrition, Epidemiology, and Publicity and Education.

Shortly after its inception, the new Medical Investigation Division was declared by the Deputy Minister of Pensions and National Health to be "[probably] the most interesting division of the Department."[185] The Department took part in a conference on medical research in Ottawa in February 1938, part of the reason for which was to decide what types of medical research it would be most valuable for Canada to embark upon,[186] but the real antecedents for this new Division are to be found in medical investigation of the civil service, something the Department had been involved in heavily since 1935 and casually for at least a decade before that.[187] Originally, the Department was only to check certificates presented by employees to various government departments for the purposes of obtaining sick leave and to examine anyone seeking superannuation for reasons of illness.[188] In the fiscal year ending 31 March 1935 alone, the Department dealt with 7500 cases involving 16,600 medical certificates and 3600 personal examinations. For this work, the Department employed two full-time and two part-time medical officers, two full-time stenographers, one part-time bilingual stenographer and one full-time recording clerk.[189]

It seems astounding that a Department cut to the bone fiscally should put such priority on policing the health of civil servants.

The justification was that only by close examination to discover what illnesses cost the most loss in sick days, could adverse conditions be ameliorated and the physical efficiency of civil servants be improved.[190] In other words, the Department could supposedly make back money it spent on these investigations by giving advice that would keep civil servants from becoming ill. However, there is another conclusion which perusal of the records makes inescapable--the Department was looking for dead-beats, or as the Deputy Minister called them, sufferers from "civil servicitis."[191] It was noted that in cases of some people with bad attendance records, all that was needed was "a quiet discussion of the situation . . . to permit the acquiring of an improved mental attitude towards his or her invironment [sic], and a consequent improvement in efficiency."[192] With its establishment as a full-fledged Division in 1938, Medical Investigation did take on broader duties. It had for some time tried to isolate the most prevalent types of injuries and diseases to which government workers were prone with the idea of extrapolating from any findings to arrive at predictions for the state of health of all Canadians,[193] and it now branched out into studies on syphilis among pensioned soldiers[194] and on rheumatic diseases among the general population.[195] But even so, the newly-established Division did not shed its old watch-dog role. The year it was set up, it was pushing for authorization to institute an adequate pre-employment medical examination "as a safeguard for the Civil Service superannuation fund"[196] and insisting that a majority of sick leaves were often the result of maladjustment exaggerating "a trifling physical disturbance."[197] The Department claimed success in its attentions to the health of civil servants. Near the end of the Depression, average time off sick per person per annum was only one and a half days and statutory sick leave had been reduced from twelve to eight days a year.[198] The Division would function throughout World War II, which emergency would take its mind more and more off indiligence in the civil service.

Neither, of course, was Child and Maternal Hygiene a brand new division. Re-establishment of the former Division of Child Welfare had been called for ever since its abolition and the transferral of its duties to the Canadian Council on Child and Family Welfare on 1 January 1934. The transfer had been greeted almost immediately with dissenting resolutions passed by the Canadian Public Health, Medical and Nurses Associations. The Canadian Dental Association complained about difficulties in working with the director of the Council, Charlotte Whitton.[199] Members of Parliament rose in the House to complain about this important medical problem being "put into the hands of a university graduate"[200] and to ask what other moves were being taken for "transferring over to famous ladies or others the duties of the department in regard to public health."[201] The Department and the Council certainly had their problems working together. Funds generally fell short of promises,[202] and Whitton threatened to resign at least once.[203] Maternal and Child Hygiene was only one of eight major divisions of the Council[204] and already by the time of its 1935 annual report it expressed a desire to sign it back over to the Department.[205] In 1936, the Canadian Medical Association produced a report from its Committee on Maternal Welfare. It strongly recommended that the federal department resume its duties in this field. The report was read before the Dominion Council of Health in late 1936[206] and in October 1937 the Division was re-established under the designation of Child and Maternal

Hygiene, complete with two technical advisory committees--one of "outstanding paediatricians, the other of similarly well-qualified obstetricians."[207] The four year respite had wrought no changes in Departmental beliefs about where its duty lay in the fight against Canada's unenviable infant and maternal mortality rate. Acknowledging that in a recent list made of the relevant rates for twenty-six countries, Canada came out twenty-second best, the Department decided that the best way to cut this down was once again to make an educational assault on the public whose indifference and ignorance were held responsible for the failure to seek--indeed to demand--adequate pre-natal care.[208] The Division proceeded, as before, to launch a campaign of survey, publication and propaganda.[209] These activities would extend into and beyond World War II, by which time Canada's infant and maternal mortality rates were dropping due to reasons of better living conditions and medical technology.

Interest in two of the other concerns taken over by the Department was of more recent origin. Nutrition was to be handled by a separate council rather than by a Departmental division. Although not a new topic of conversation within the Dominion Council of Health,[210] fascination with the nutritional standard of Canadians picked up smartly with the Depression. The amount of relief set aside for food had, by and large, more to do with available moneys than with the amount and type of food needed per person per day.[211] Canadian health officials realized the long-term dangers implicit in asking people to get along on what they could purchase with their reduced means.[212] United States authorities likewise worried that those on relief might not have the ingenuity to adjust to reduced circumstances.[213] In October 1937, the

DCH decided to set up a committee to take the first step towards providing better nutrition for Canadians. Five members of the Council were asked to band together with five technical people of their choice in order to start determining just what constituted an adequate diet.[214] By March 1938, the Canadian Council on Nutrition was working on two food surveys largely under the aegis of the Dominion Bureau of Statistics and thanks to funds from the Milbank Memorial Fund.[215] By this time the Council had swollen to thirty-three members, chaired by the Deputy Minister of Pensions and National Health, R. E. Wodehouse. Charged with the duty of collecting and distributing information,[216] its activities were at first held up by reason of being turned down for funds by the Rockefeller Foundation,[217] but this was remedied in early 1939, when the federal government began to take more interest and granted some seed money[218] for dietary surveys in four major cities.[219] With the outbreak of World War II, nutrition would take on greater urgency and the Council greater importance.[220]

The Division of Epidemiology would not enjoy such longevity. Seemingly established in response to a plague scare, its urgency would fade away along with the alarum. Surfacing in Vancouver, fear of plague had its origins in concern over the war in the Far East. Epidemic disease was a traditional concomitant of war, plague the most dreaded of all. Canadian quarantine officials on the west coast were put in the *qui vive.*[221] Concern overflowed to include sylvatic plague and Rocky Mountain Spotted Fever (a relative of typhus), both diseases endemic in the rodent populations of the western states and provinces and both transferable to humans via fleas and ticks.[222] Obtaining money from the stalwart Rockefeller Foundation, the Department, in conjunction with

British Columbia and Alberta, put two research vehicles into the field and added special facilities at existing western laboratories.[223] After an expenditure on the part of the federal government of nearly one hundred thousand dollars,[224] results were found to be anything but frightening, the little infection that was found being low-grade.[225] Fortunately, this was not the only result produced by the Division of Epidemiology. During its first year of operation, it produced a memorandum on health services at the request of the Royal Commission on Dominion-Provincial Relations. It hoped to continue this work by doing an exhaustive study on the threat of communicable diseases to Canadian health, perhaps finally to come up with some answers regarding the extent of ill health in the country.[226] The next year it investigated, in addition to Rocky Mountain Spotted Fever, two other diseases endemic in animals and transferable to humans--tularemia (in rabbits) and encephalomyelitis (in horses).[227] But the major threats to Canadian health were not to be found among the communicable diseases. This had already been shown by the fall in status of the quarantine divisions. The Department would continue to take an interest in provincial initiatives in the field of epidemiology but it disbanded its own separate division after only two years.

To co-ordinate all the information shortly expected to pour forth at greater strength from its new and old divisions, the Department re-established a separate section for the purpose of co-ordinating it all. But the duties of the Publicity and Health Education Division were not simply publicity but propaganda, not simply the release of information but agitation for its implementation. Although there had been some talk of the Department taking over some of the provincial activities in the field of health publishing,[228] the new Division was meant to add to information already being released by the provinces and voluntary organizations.[229] The director was to supervise "an intensive campaign of publicity in the interests of public health throughout the nation" by preparing booklets, issuing health copy to the press, furnishing daily health bulletins to radio stations and designing exhibits.[230] In a well-orchestrated advertising campaign, the Division set about creating a demand for the publications of the various Departmental divisions. Although it drummed up some business through the time-honored use of exhibits at local fairs,[231] there can be no doubt that the best medium was the radio. By the end of 1938, the Division had managed to get free time for its "Healthograms" on stations coast to coast.[232] Approximately fifty letters a day in both French and English came to the Department as a response.[233] Most asked for more information and the Division obligingly sent out sixty thousand pamphlets in the fiscal year ending 31 March 1939, alone.[234] Listeners to the radio could also hear special features, such as the Department's Director of Public Services, J. J. Heagerty, give a ten-week series called "The Romance of Medicine in Canada"[235] and fifteen minute scripts--dramatizing such things as the evils of alcohol--prepared by voluntary organizations under Departmental guidance.[236] Readers of newspapers could also profit from Departmental findings. The Division regularly provided the press with releases on questions such as "influenza, the common cold, pneumonia, bronchitis, heart disease, worry, diseases of middle age, relaxation, humidity, winter ailments, air conditioning, child and maternal hygiene, the 'Iron Lung,' undulant fever, plague surveys, etc."[237] By the time Canada entered the war, investigations were being made into the feasibility of agitating for better health practices through the media of posters and moving pictures.[238] But, possibly ambitious beyond its means, the Division would disappear in 1945, a victim of wartime budget constraints.[239]

The new divisions were real attempts to come to grips with deficiencies in Canadian health care. However, they were not enough. All fitted neatly into either or both of the federal government's accepted tasks of quarantine and publicity. Adherence to these duties had not made significant contributions to the standard of health in the 1920s. The appearance in the 1930s of their impotence to ameliorate conditions made it difficult for the Department to fight successfully the budget cuts aimed at non-essential services. If progress were to be made, a new direction must be taken. That things could not go on as they were was agreed upon by health officials, reformers, politicians and the public. Agitation for reform went on throughout the Depression rising to a crescendo towards the end of the decade. The report on health collected by the Royal Commission on Dominion-Provincial Relations was only one of the studies coming out of this period. Most were not completed and released until after war had been declared. All were constructed on the assumption that there would be no easy way out of the swamp--that the Canadian health care system must undergo real qualitative and quantitative reform, that the whole philosophy of medical care must change, that stopgap solutions must not be resorted to, that the Department must take the lead in finding a way to guarantee a higher standard of Canadian health. At the beginning of World War II, the Department thought its answer lay in national compulsory health insurance; by the end, it would be forced to abandon this dream and gradually drift away from health to welfare reforms.

NOTES

[1] PAC, RG 29, vol. 1062 (file 502-1-1, part 1) Letter, Heagerty to H. E. Spencer, M.P., 26 Apr. 1930.

[2] W. J. Bell, "Trends in Public Health and Medical Care in Canada," *CPHJ*, XXV (July 1934), 317.

[3] *Ibid.*, p. 316.

[4] Strong, p. 227.

[5] Harry M. Cassidy, *Public Health and Welfare Organization: The Postwar Problem in the Canadian Provinces* (Toronto: Ryerson, 1945), p. 10.

[6] *Report, PNH, 1931*, p. 127.

[7] *Ibid., 1930*, p. 115.

[8] Quoted in Grace Abbott, *From Relief to Social Security. The Development of the New Public Welfare Services and their Administration* (Chicago: The University of Chicago Press, 1941), p. 291.

[9] PAC, RG 29, vol. 19 (file 10-3-1, part 2) Clipping from the Montreal *Star*, 26 Jan. 1937.

[10] A. E. Grauer, *Public Health* (Ottawa: King's Printer, 1940), p. 2.

[11] S. D. Collins and C. Tibbitts, *Research Memorandum on Social Aspects of Health in the Depression* (New York: Social Science Research Council, 1937), p. viii.

[12] PAC, DCH Minutes, 19th meeting, 18-20 Nov. 1929, pp. 28-33.

[13] *Ibid.*, 33rd meeting, 2-3 Nov. 1936, pp. 11-6.

[14] Collins and Tibbitts, p. 6.

[15] See the discussion in Leonard C. Marsh, *Health and Unemployment: Some Studies of their Relationships* (Toronto: Oxford University Press, 1938), pp. 20-7.

[16] *Ibid.*, pp. xxi-xxii.

[17] Harry M. Cassidy, *Unemployment and Relief in Ontario, 1929-1932* (Toronto: J. M. Dent and Sons, 1932), pp. 247-50, 273. PAC, DCH Minutes, 23rd meeting, 15-17 Dec. 1931, pp. 5-6.

[18] Angus MacInnis, Commons, *Debates*, 1934, p. 659. PAC, RG 29, vol. 1062 (file 502-1-1, part 4) G. M. Weir, "Health Insurance and our People," radio speech delivered 28 Nov. [1935?].

[19] Marsh, *Health and Unemployment*, particularly 35-172.

[20] *Ibid.*, p. 15.

[21] Cassidy, *Unemployment and Relief*, p. 266. His emphasis.

[22] Marsh, *Health and Unemployment*, pp. xxii-xxiii.

[23] *Ibid.*, p. 3.

[24] Collins and Tibbitts, pp. 38-40.

[25] National Committee for Mental Hygiene (Canada), *Study of the Distribution of Medical Care and Public Health Services in Canada* (Toronto: The National Committee for Mental Hygiene [Canada], 1939), p. 77.

[26] I. D. Cotnam, Commons, *Debates*, 1931, p. 1005.

[27] Marsh, *Health and Unemployment*, p. xxiii.

[28] Cassidy, *Unemployment and Relief*, p. 254.

[29] PAC, DCH Minutes, 28th meeting, 14-15 June 1934, p. 24.

[30] *Ibid.*, 31st meeting, 2 Dec. 1935, pp. 19-23.

[31] *Report, PNH, 1932*, p. 106. PAC, DCH Minutes, 26th meeting, 13-15 June 1933, pp. 62-4.

[32] Marsh, *Health and Unemployment*, pp. 28 and 184.

[33] H. E. Spencer and Peter Heenan, Commons, *Debates*, 1932, pp. 3418-9.

[34] *Ibid.*, 1934, p. 434.

[35] Cassidy, *Unemployment and Relief*, p. 78. PAC, DCH Minutes, 26th meeting, 13-15 June 1933, pp. 62-4.

[36] Leonard C. Marsh, *Social Security for Canada* (Ottawa: King's Printer, 1943), p. 24.

[37] David A. Niven, Commons, *Debates*, 1937, p. 2637.

[38] Cassidy, *Unemployment and Relief*, p. 254.

[39] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, p. 7.

[40] Niven, Commons, *Debates*, 1937, p. 2637.

[41] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, Appendix B.

[42] *Ibid.*, pp. 4-5.

[43] Jean-François Pouliot, Commons, *Debates*, 1936, p. 2166.

[44] Arthur Denis, *ibid.*, 1931, p. 1007.

[45] PAC, DCH Minutes, 27th meeting, 16-18 Oct. 1933, p. 90. For example, Alberta; see Collins, pp. 107-35.

[46] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, Appendix C.

[47] *Ibid.*, 2nd meeting, 17-19 May 1920, pp. 22-4.

[48] *Ibid.*, 31st meeting, 2 Dec. 1935, pp. 7-8.

[49] *Ibid.*, 32nd meeting, 15-16 June 1936, p. 3.

[50] *Ibid.*, 25th meeting, 31 Oct. - 2 Nov. 1932, p. 53.

[51] *Ibid.*, 30th meeting, 6-8 June 1935, p. 9. PAC, RG 29, vol. 182 (file 302-1-7) Letter, F. W. Jackson, Deputy Minister of Health for Manitoba to Wodehouse, 25 Feb. 1935.

[52] PAC, DCH Minutes, 34th meeting, June 1937, pp. 1-2.

[53] PAC, RG 29, vol. 40 (file 35-2-9, part 1) Letter, R. E. Wodehouse to G. M. Weir, provincial secretary of B.C., 14 Feb. 1938.

[54] PAC, DCH Minutes, 32nd meeting, 15-16 June 1936, Appendix B.

[55] *Ibid.*, 37th meeting, 6-7 Dec. 1938, p. 19.

[56] *Ibid.*, 29th meeting, 29 Nov. - 1 Dec. 1934, Appendix K; *ibid.*, 30th meeting, 6-8 June 1935, pp. 6-7. PAC, RG 29, vol. 182 (file 302-1-8).

[57] PAC, DCH Minutes, 19th meeting, 18-20 Nov. 1929, pp. 23-4.

[58] *Ibid.*, 13th meeting, 8-10 Dec. 1925, p. 17.

[59] PAC, RG 29, vol. 901 (file 435-1-6) Letter, Minister of Pensions and National Health to all provinces, 2 Mar. 1931.

[60] PAC, RG 29, vol. 182 (file 302-1-7) To Acting Deputy Minister of Health, 29 May 1933.

[61] *Ibid.*, Correspondence, July - Oct. 1933 and Nov. 1934.

[62] *Ibid.*, Adams to Wodehouse, 13 Nov. 1934.

[63] *Ibid.*, Report of a special meeting on reciprocal interprovincial agreements regarding hospitalization of interprovincial transients, Ottawa, 16 June 1936.

[64] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, p. 11.

[65] PAC, RG 29, vol. 901 (file 435-1-6) Letter, Jean Grégoire to Wodehouse, 11 Jan. 1939.

[66] PAC, DCH Minutes, 26th meeting, 13-15 June 1933, p. 25.

[67] *Ibid.*, 24th meeting, 28-31 May 1932, pp. 23-4.

[68] For example, they were expected to take over some of the work of the VD clinics expected to close down due to cancellation of federal funding. *Ibid.*, pp. 13-5.

[69] *Ibid.*, 25th meeting, 31 Oct. - 2 Nov. 1932, pp. 71-2. One municipality figured that, if it tried to subsidize its doctor, it would have to close the hospital and the school. *Ibid.*, 24th meeting, 28-31 May 1932, p. 25-7.

[70] *Ibid.*, 29th meeting, 29 Nov. - 1 Dec. 1934, pp. 9-10.

[71] Collins and Tibbitts, pp. 162-4.

[72] PAC, RG 29, vol. 23 (file 21-1-1) Memorandum on Social Insurance, pp. 5-6.

[73] PAC, RG 29, vol. 182 (file 302-1-6) Letter, T. C. Routley of CMA to Heagerty, 9 Feb. 1932.

[74] *Ibid.*, Letter, Dr. H. M. Harrison, Director of CMA to Heagerty, 24 Feb. 1934.

[75] The fee was soon raised to seven dollars. PAC, DCH Minutes, 29th meeting, 29 Nov. - 1 Dec. 1934, Appendix I.

[76] PAC, RG 29, vol. 991 (file 499-3-2, part 2) Letter, Mrs. Leonard Renaud [sic] of Wawbewawa, Ont., to Department, 10 July 1935.

[77] Collins, p. 54.

[78] See PAC, RG 29, vol. 97 (file 56-2-2).

[79] Cassidy, *Unemployment and Relief*, p. 267.

[80] Marsh, *Health and Unemployment*, p. xx.

[81] See debate in Commons, *Debates*, 1932, pp. 1817-21.

[82] PAC, RG 29, vol. 23 (file 21-1-1) Memorandum regarding "Overlapping" [Jan. 1933?], p. 2; C. G. Power, Commons, *Debates*, 1936, p. 1092.

[83] J. P. Howden, Commons, *Debates*, 1932, p. 1326.

[84] PAC, DCH Minutes, 26th meeting, 13-15 June 1933, pp. 62-4.

[85] Alexander M. Young, Commons, *Debates*, 1936, p. 1092.

[86] PAC, DCH Minutes, 26th meeting, 13-15 June 1933, pp. 103-4.

[87] *Ibid.*, 27th meeting, 16-18 Oct. 1933, pp. 90-1.

[88] *Ibid.*, 29th meeting, 29 Nov. - 1 Dec. 1934, Appendix A; 34th meeting, June 1937, pp. 14-6.

[89] Cassidy, *Social Security and Reconstruction*, p. 26.

[90] *Report, PNH, 1930*, p. 115.

[91] Grace McInnis, *J. S. Woodsworth: A Man to Remember* (Toronto: Macmillan, 1953), pp. 207-8.

[92] *Report, PNH, 1931*, pp. 127-9.

[93] *Ibid., 1932*, pp. 123-4.

[94] *Ibid., 1934*, p. 114.

[95] See Chapter 4 above.

[96] PAC, DCH Minutes, 35th meeting, 15-16 Oct. 1937, pp. 6-7.

[97] *Ibid.*, 20th meeting, 3-5 June 1930, p. 19.

[98] *Ibid.*, 24th meeting, 28-31 May 1932, pp. 27-8.

[99] *Ibid.*, 27th meeting, 16-18 Oct. 1933, pp. 69-72. Due to lack of funds it never occurred. *Ibid.*, 28th meeting, 6-8 June 1934, pp. 22-4.

[100] *Ibid.*, 37th meeting, 6-7 Dec. 1938, Appendix E.

[101] PAC, RG 29, vol. 259 (file 347-1-6A, part 1) Letter, Heagerty to J. L. Hollinshead, Alberta Inspector of Food and Drugs, 14 Dec. 1932.

[102] PAC, DCH Minutes, 35th meeting, 15-16 Oct. 1937, p. 4.

[103] *Ibid.*, 25th meeting, 31 Oct. - 2 Nov. 1932, p. 64.

[104] *Ibid.*, 37th meeting, 6-7 Dec. 1938, p. 26.

[105] *Ibid.*, 20th meeting, 3-5 June 1930, pp. 22-3.

[106] *Ibid.*, 25th meeting, 31 Oct. - 2 Nov. 1932, p. 64.

[107] *Ibid.*, 36th meeting, 14-16 June 1938, p. 8.

[108] *Ibid.*, 34th meeting, June 1937, p. 4.

[109] *Ibid.*, 35th meeting, 15-16 Oct. 1937, p. 4.

[110] *Ibid.*, 26th meeting, 13-15 June 1933, pp. 6-7.

[111] Power, Commons, *Debates*, 1939 (1st session), p. 618.

[112] See Commons, *Debates*, 1932-33, pp. 3754, 3834-5, 3936-7, 4036-43; 1934, pp. 3277-3323; 1938, pp. 755, 1361-4, 3320-5, 3411-4, 3628-32, 3849-51.

[113] Marsh, *Health and Unemployment*, p. 175.

[114] *Ibid.*, pp. 176-207.

[115] PAC, RG 29, vol. 23 (file 21-1-1) Memorandum re Social Insurance [Jan. 1933?], pp. 2-3.

[116] PAC, DCH Minutes, 9th meeting, 11-13 Dec. 1923, pp. 28-40.

[117] *Ibid.*, 12th meeting, 11-13 June 1925, pp. 8-12, 25; 21st meeting, 10-12 Dec. 1930, p. 54.

[118] *Ibid.*, 13th meeting, 8-10 Dec. 1925, Letter from Frances Tessier of the Child Welfare Council; 14th meeting, 26-28 Oct. 1926, pp. 33-6.

[119] *Ibid.*, 16th meeting, 12-14 Oct. 1927, Letter from United Farmers to C. E. Flett, a member of the DCH.

[120] *Ibid.*, 17th meeting, 19-21 June 1928, pp. 11-7.

[121] *Ibid.*, p. 39.

[122] *Ibid.*, 18th meeting, 4-6 Dec. 1928, pp. 4-8.

[123] C.J.W. Beckwith, "The Cape Breton Island Health Unit," *CPHJ*, XXX (July 1939), 343-7.

[124] PAC, DCH Minutes, 17th meeting, 19-21 June 1928, pp. 26-32.

[125] H. E. Spencer, Commons, *Debates*, 1930, pp. 217-8.

[126] PAC, DCH Minutes, 18th meeting, 4-6 Dec. 1928, pp. 16-7, 33-7.

[127] *Ibid.*, 17th meeting, 19-21 June 1928, p. 3.

[128] *Ibid.*, 18th meeting, 4-6 Dec. 1928, p. 37.

[129] J. H. King, Commons, *Debates*, 1929, p. 2981.

[130] PAC, DCH Minutes, 19th meeting, 18-20 Nov. 1929, pp. 6-7.

[131] H. E. Spencer, Commons, *Debates*, 1930, p. 217.

[132] PAC, DCH Minutes, 20th meeting, 3-5 June 1930, p. 11.

[133] *Ibid.*, 21st meeting, 10-12 Dec. 1930, pp. 28-33 and Resolution 2.

[134] Commons, *Debates*, 1931, pp. 996-1104 and 1688-93.

[135] PAC, DCH Minutes, 22nd meeting, 23-25 June 1931, pp. 1-14.

[136] *Ibid.*, 23rd meeting, 15-17 Dec. 1931, p. 32.

[137] PAC, RG 29, vol. 182 (file 302-1-9) Memo on health units; vol. 23 (file 21-1-1) Memorandum re Social Insurance, pp. 2-5. PAC, DCH Minutes, 24th meeting, 28-31 May 1932, pp. 2-4; 26th meeting, 13-15 June 1933, p. 84.

[138] National Committee for Mental Hygiene (Canada), pp. 176-7.

[139] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, pp. 19-21.

[140] Wodehouse, *ibid.*, 33rd meeting, 2-3 Nov. 1936.

[141] PAC, RG 29, vol. 23 (file 21-1-1) Interprovincial Conference, 26 Oct. 1934, pp. 6-7. Marsh, *Health and Unemployment*, pp. 192-4.

[142] Grauer, *Public Health*, p. 9.

[143] F. W. Jackson, "Morbidity Survey in the Municipal Doctor Areas in Manitoba," *CPHJ*, XXXII (Oct. 1941), 492-3.

[144] J. T. Phair, "State Medicine," editorial, *CPHJ*, XXII (Nov. 1931), 574-5.

[145] PAC, DCH Minutes, 25th meeting, 31 Oct. - 2 Nov. 1932, pp. 49-51.

[146] Peebles, p. 468.

[147] "Discussion of State Medicine in Saskatchewan," *CPHJ*, XXVII (Dec. 1936), 616.

[148] H. Blair Neatby, "The Saskatchewan Relief Commission, 1931-1934," *Saskatchewan History*, III (Spring 1950), 51-2, quoted in Michiel Horn, ed., *The Dirty Thirties. Canadians in the Great Depression* (Toronto: Copp Clark, 1972), p. 276.

[149] Health Study Bureau, *Review of Canada's Health Needs and Health Insurance Proposals* (Toronto: the Board, 1945), p. 2.

[150] PAC, DCH Minutes, 31st meeting, 2 Dec. 1935, Appendix B, a circular letter to all members of the Ontario Medical Association from T. C. Routley, Secretary.

[151] Shillington, p. 36.

[152] Marsh, pp. 178-83.

[153] "New plan for unemployment relief in Ontario," *CPHJ*, XXVI (Mar. 1935), 144.

[154] PAC, DCH Minutes, 26th meeting, 13-15 June 1933, pp. 103-4.

[155] *Ibid.*, 31st meeting, 2 Dec. 1935, Appendix B, letter to OMA from Routley.

[156] Marsh, *Health and Unemployment*, p. 205.

[157] Bell, pp. 318-9.

[158] PAC, DCH Minutes, 25th meeting, 31 Oct. - 2 Nov. 1932, p. 46; 27th meeting, 16-18 Oct. 1933, pp. 23-4. J. C. McMillan, "A Proposed scheme of health insurance for Manitoba," *CPHJ*, XXVI (Mar. 1935), 105-9.

[159] See Matters, pp. 28-32.

[160] P.A.T. Sneath, "Current Public Health Comment: Health Insurance in British Columbia," *CPHJ*, XXVII (June 1936), 302.

[161] PAC, RG 29, vol. 23 (file 21-1-1) Interprovincial Conference [26 Oct. 1934?], p. 6.

[162] Sneath (June 1936), pp. 302-3. PAC, RG 29, vol. 1062 (file 502-1-1, part 4) Recent Developments in Public Health and Medical Services in Canada [1935?], pp. 4-8. Peebles, p. 468. P.A.T. Sneath, "Current Public Health Comment: Health Insurance in British Columbia," *CPHJ*, XXVII (Mar. 1936), 147-50. PAC, RG 29, vol. 1062 (file 502-1-1, part 4) Summary of British Columbia's Health Insurance Bill [1936?].

[163] Sneath (June 1936), p. 303.

[164] PAC, RG 29, vol. 1062 (file 502-1-1, part 4) Letter, Heagerty to Deputy Minister of Justice, 15 Aug. 1936.

[165] Hugh H. Wolfenden, "Insurance and Public Health," *CPHJ*, XXV (July 1934), 307-15.

[166] PAC, DCH Minutes, 24th meeting, 28-31 May 1932, p. 4.

[167] Robert S. Bothwell and John R. English, "Pragmatic physicians: Canadian Medicine and health care insurance, 1910-1945," *University of Western Ontario Medical Journal*, XLVII (March 1976), 15.

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[169] PAC, RG 29, vol. 1062 (file 502-1-1, part 4) G. M. Weir, "Health Insurance and our People" in *The Bulletin of the British Columbia Board of Health*, V (Dec. 1935), 141-9.

[170] "Plebiscite on Health Insurance in British Columbia," *CPHJ*, XXVIII (June 1937), 305.

[171] "Health Insurance Plebiscite in British Columbia," *CPHJ*, XXVIII (Aug. 1937), 412.

[172] Cassidy, *Social Security and Reconstruction*, p. 23.

[173] Collins, p. 122.

[174] *Ibid.*, pp. 122-30. A. C. McGugan, "Alberta State Health Insurance Report," *CPHJ*, XXV (Apr. 1934), 155-60.

[175] Wolfenden, pp. 307-12. PAC, RG 29, vol. 1062 (file 502-1-1, part 3) Memorandum on the Progress Report of the Commission Appointed by the Legislature in Alberta, by Hugh H. Wolfenden, 16 pages.

[176] Peebles, p. 467.

[177] PAC, DCH Minutes, 34th meeting, June 1937, pp. 14-6.

[178] PAC, RG 29, vol. 1062 (file 502-1-1, part 1) Letter, Heagerty to C. H. Gibbon, Secretary of B.C. Royal Commission on State Health Insurance and Maternity Benefits, 10 Sept. 1930.

[179] For example, PAC, DCH Minutes, 22nd meeting, 23-25 June 1931, pp. 15-35; 30th meeting, 6-8 June 1935, p. 9.

[180] J. J. Heagerty, "National Health Section, Department of Pensions and National Health," *CPHJ*, XXVIII (Apr. 1937), 200.

[181] PAC, DCH Minutes, 29th meeting, 29 Nov. - 1 Dec. 1934, Appendix H; 32nd meeting, 15-16 June 1936, Appendix A: 34th meeting, June 1937, p. 14. PAC, RG 29, vol. 181 (file 300-2-1, parts 3 and 4) and vol. 501 (file 311-V3-34, part 1).

[182] "Dominion leadership in public health," *CPHJ*, XXVI (May 1935), 252.

[183] Commons, *Debates*, 1937, p. 101.

[184] Power, *ibid.*, pp. 100-1. PAC, DCH Minutes, 34th meeting, June 1937, pp. 8-11.

[185] Wodehouse, p. 373.

[186] PAC, RG 29, vol. 613 (file 339-1-3).

[187] *Report, PNH, 1935*, p. 134.

[188] PAC, RG 29, vol. 23 (file 21-1-1) Heagerty, Activities of the National Health Division, p. 32.

[189] *Report, PNH, 1935*, p. 134.

[190] *Ibid.*, p. 136.

[191] Wodehouse, p. 374.

[192] *Report, PNH, 1936*, p. 160.

[193] *Ibid., 1937*, p. 129.

[194] *Ibid., 1940*, pp. 148-50.

[195] *Ibid., 1939*, pp. 154-5.

[196] *Ibid., 1938*, p. 144.

[197] *Ibid.*, p. 145.

[198] Wodehouse, p. 374.

[199] PAC, RG 29, vol. 991 (file 499-3-2, part 1) Minutes of the Division of Maternal and Child Hygiene of the Canadian Council on Child and Family Welfare, Ottawa, 14 June 1934.

[200] PAC, RG 29, vol. 97 (file 156-2-2) Memo from Wodehouse to MacLaren, 1 June 1934.

[201] Sir Eugene Fiset, Commons, *Debates*, 1934, p. 1683.

[202] PAC, RG 29, vol. 97 (file 156-2-2) Memo from Wodehouse to MacLaren, 1 June 1934.

[203] PAC, RG 29, vol. 991 (file 499-3-2, part 1) Minutes, 14 June 1934.

[204] C. G. Power, Commons, *Debates*, 1936, p. 1086.

[205] PAC, RG 29, vol. 991 (file 499-3-2, parts 3, 4, 5) and vol. 992 (file 499-3-2, part 6) Annual Report, 1935.

[206] PAC, DCH Minutes, 33rd meeting, 2-3 Nov. 1936, Appendix C.

[207] Wodehouse, p. 372.

[208] *Report, PNH, 1938*, p. 138.

[209] See *ibid., 1939*, pp. 140-6 and *1940*, pp. 142-5.

[210] PAC, DCH Minutes, 14th meeting, 26-28 Oct. 1926, pp. 36-7; 18th meeting, 4-6 Dec. 1928, p. 31.

[211] Cassidy, *Unemployment and Relief*, pp. 183-6.

[212] PAC, DCH Minutes, 24th meeting, 28-31 May 1932, pp. 27-8.

[213] E. W. McHenry, "Nutrition and the Depression," editorial, *CPHJ*, XXVII (July 1936), 342.

[214] PAC, DCH Minutes, 35th meeting, 15-16 Oct. 1937, pp. 6-8.

[215] Wodehouse, p. 371.

[216] *Report, PNH, 1938*, pp. 146-8.

[217] PAC, RG 29, vol. 885 (file 20-R-3) Correspondence between Wodehouse and Dr. John A. Ferrell of the Foundation, Nov.-Dec. 1938.

[218] Power, Commons, *Debates*, 1939 (1st session), p. 4374.

[219] PAC, DCH Minutes, 38th meeting, 15-17 June 1939, pp. 12-3.

[220] *Report, PNH, 1940*, pp. 153-5.

[221] PAC, DCH Minutes, 35th meeting, 15-16 Oct. 1937, p. 9.

[222] *Ibid.*, 31st meeting, 2 Dec. 1935, Appendix A: 37th meeting, 6-7 Dec. 1938, pp. 21-4.

[223] *Report, PNH, 1938*, p. 140.

[224] Power, Commons, *Debates*, 1939 (1st session), p. 2703.

[225] Wodehouse, pp. 371-3.

[226] *Report, PNH, 1938*, p. 141. PAC, RG 29, vol. 23 (file 21-1-1) Activities of Dominion and Provincial Departments in respect to Overlapping.

[227] *Report, PNH, 1939*, pp. 148-52.

[228] PAC, DCH Minutes, 34th meeting, June 1937, pp. 3-4.

[229] PAC, RG 29, vol. 110 (file 181-1-1) Memorandum, Heagerty to Wodehouse, 3 Feb. 1938.

[230] Power, Commons, *Debates*, 1939 (1st session), p. 618.

[231] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, Appendix E.

[232] *Ibid.*, p. 26. Wodehouse, p. 371.

[233] PAC, RG 29, vol. 117 (file 186-1-4) Memorandum, F. W. Rowse, Director of Publicity and Health Education Division to Heagerty, 18 Nov. 1938.

[234] *Report, PNH, 1939*, p. 158.

[235] PAC, RG 29, vol. 123 (file 190-4-1, part 1) Heagerty was chosen partly because he had a "radio voice."

[236] PAC, RG 29, vol. 121 (file 190-1-2).

[237] *Report, PNH, 1939*, p. 156.

[238] *Ibid.*, *1940*, p. 151.

[239] *Ibid.*, *1944*, p. 67.

> I think we have come now almost to the time when the people do not care whether health is a federal or a provincial matter. What they do care about is [that it is] a human matter. One hears people talking everywhere about the necessity for state medicine or health insurance or some way of taking care of the sick.
> --Agnes Campbell MacPhail, in the House of Commons, 6 March 1939.

Chapter Seven

ANOTHER WAR, ANOTHER REFORM

SOCIAL WELFARE, NOT STATE MEDICINE

In December 1938, the Minister of Pensions and National Health, C. G. Power, opened his remarks to a regular meeting of the Dominion Council of Health with the assertion that "there has grown up in the past few years a health consciousness that is very gratifying."[1] Indeed, it seemed by the end of the 1930s that everyone was talking about health. Daniel McIvor noted that in preparing a resolution on health to be presented before the House of Commons he and others had not had to rely strictly on whatever first-hand data they could compile.

> We have also listened to many radio addresses; we have had information from health magazines, and from material disseminated by health boards throughout Canada. Many of our church leaders have also given us much health [sic].[2]

The Protestant churches took particular interest in the subject,[3] but so did secular bodies such as the Buffalo Plain [Saskatchewan] Home Makers club. Even members of parliament, who certainly debated the subject often enough during working hours, found health a topic sufficiently interesting to be pursued in semi-informal situations. While attending the annual banquet of the Royal College of Physicians and Surgeons in Ottawa in late 1933, Prime Minister R. B. Bennett revealed his own prescription for health and longevity: "No smoking, no drinking, no worry, not much exercise and six or seven hours sleep."[4] But agreement that health was a good topic of debate did not imply similar agreement as to how good health was to be brought about or maintained. To demonstrate the opposite poles, the Buffalo Plain Home Makers wanted "amediate [sic] steps to institute a system of state medicene [sic]"[5] while Bennett stated that such a thing had no place in a young and growing country and that it would be a long time "before we have state medicine in this country so far as the Dominion is concerned."[6]

Part of the problem with the debate was that the terms, especially that of "state medicine," were never adequately defined. Some felt state medicine was just a natural extension of the type of medical relief coaxed out of the various governments as part of public assistance during the Depression.[7] Others only wondered if this were so.[8] The president of the Canadian Medical Association lamented by mid-decade that it was already too late: "State medicine in its most repugnant form is already entrenched."[9] Various members of the House of Commons were not so sanguine and almost yearly a resolution was introduced before that body sometimes asking for state medicine by name, at others avoiding the use of the term.[10] By the end of the 1930s another phrase, that of "health insurance," had taken precedence. Sometimes it was used interchangeably with state medicine but mostly it designated a less objectionable alternative. One former employee of the Saskatchewan municipal doctor system spoke out vehemently in the House in 1938 against state medicine but supported the concept of compulsory health insurance.[11] Three years later, high emotions had been transferred to the more immediate problems of national defence and the members of the medical profession were no longer reacting so violently to the menace of state medicine. Dr. Wilder Penfield, president of the College of Physicians and Surgeons, felt he spoke "for the Fellows when I say that it is obvious that some form of State Medicine is bound to come and in all justice Health Insurance should be started on a Dominion wide basis now."[12] Public health officials even felt free to treat the subject with some jocularity. A. Grant Fleming of the National Council for Mental Hygiene joked, in the presence of Dr. Duncan Graham, president of the CMA who had just averred that he supported health insurance but that "the Association is against State Medicine and against Health Insurance which operates like State Medicine,"[13] that "he liked Health Insurance and was not even afraid of State Medicine."[14] No matter what it was called, something clearly was needed. But although a whole raft of studies were started during the Depression to prove this very fact, and although the Department of Pensions and National Health had already taken some small steps,[15] it would take a war to get new initiatives at health reform off the ground.

One of the many calls for reform raised in the House between the wars demonstrated just what a mockery was Senator James Lougheed's statement, made at the end of the Great War, that "[there] is probably nothing like a war to discover the steps that should be taken for the protection of public health."[16] E. J. Garland might have stated as a corollary that there was probably nothing like a peace to discover just what steps could be skipped. He worried over the fate of the jobless wandering the country with little governmental care expended on their health and welfare. He did not accept Dominion evasions that only the provinces had the constitutional right to provide health care, that the federal government could not use its tax money in this manner. He hinted that funds could be and would be applied should these people suddenly prove of worth to the nation, as had happened at the outbreak of World War I.

> It was found worthwhile to spend lots of money on the establishment of military clinics for the building up of these men, for the improvement of their physique, for the removal of varicose veins and the adjustment of fallen arches and other defects, in order that they might be sent overseas for cannon fodder. It was simple enough to find money for that purpose. It ought to be just as simple to find money to-day.[17]

Eight years later a call from the Canadian Youth Congress for funds to improve the health of young people was still demanding immediate action.[18] Perhaps it was a little hard to justify expenditure of money to increase the efficiency of would-be workers for whom there was no need in the depressed economy. Also in 1938, J. P. Howden ridiculed this cynical attitude before the House.

> You say, "Well, what of it? There are too many people, anyway; why not let them die? To hundreds of thousands of people we are giving not only medical attention, but food, clothing and shelter. At a time like this would it not be just as well to refrain from a discussion of state medicine? Why not wait until we balance the budget, and until we settle our railway and unemployment questions?"[19]

Howden, as usual, was exposing government faults to the harshest light. Reformers were not the only ones appalled by the situation. Government officials were attempting to ameliorate some conditions and the Royal Commission on Dominion-Provincial Relations was already in action and paying some attention to health needs. Still, Howden was right, health was not very high on any government's agenda. Abandoning humanitarian arguments, he stressed instead that health should be given more importance because people carrying communicable diseases were a menace to the general population.[20] Within eighteen months such negative arguments would no longer be needed. Canada would have a positive need for healthy citizens.

The outbreak of World War II drastically increased Canada's need for workers both in the military and in industry. Although the Department of National Defence would look after soldiers, the Department of Pensions and National Health was responsible for "the health and conservation of the people of the country and especially in regard to those engaged in the field of industry."[21] First indications were not good. Early rejections on health grounds by the military were only half of what they had been for World War I but, considering that Canada had supposedly undergone twenty years of public health efforts during the interim, the results were definitely disappointing.[22] Such results did not buoy hopes that Canada had a good pool of healthy citizens from which to draw both soldiers and workers. Even more depressing, the major obstacles to a high standard of national health were the very ones that the original Department of Health had been set up in 1919 to quell--venereal disease, tuberculosis, infant and maternal mortality and, as it was now termed, mental illness.[23] These problems had not been forgotten during peace only to be remembered at the onset of war; health reformers had belabored the point for two decades. However, the national emergency acted as a catalyst. The Department of Pensions and National Health again expanded old and added new divisions. But while the problems the Department specifically dealt with were those characteristic of war, it also looked ahead to peacetime. Just as in World War I, concern for the present would spill over into concern for the future. Some sort of lasting reform clearly had to be come up with.

The arguments for reform were not strictly humanitarian--not strictly limited to convictions that Canadians endeavoring earnestly to win this war deserved some personal improvement in their lives at its end. Health reform was also seen as a measure that would, if not forestall, at least help lessen the threats of crime[24] and revolution,[25] and the spectres of another post-war epidemic[26] and a returned economic depression.[27] There was also simply a need to rationalize a situation that had grown up over the last decade. By 1937, the Dominion government was paying forty-four percent of the cost of the total welfare expenditures in Canada but had little control over how the provinces and municipalities spent the funds.[28] Clearly no government liked to perform the unpopular task of taking in taxes unless it were accompanied by the popular task of spending the money on its own programs. It was also clear that funding could not simply be cut off. What was needed was a comprehensive scheme of social security. Health insurance was the policy settled on to take care of the medical aspects of such a scheme. The Department expended a great deal of effort throughout the war in an attempt to devise a system that would allow people to take advantage of what medical care was already available and to build up Canada's health facilities and personnel. The Department's health insurance proposals would fail--partly because the scheme was not a good one, the victim of too little time, too little information and too much influence by the medical profession--but also because of failure to iron out Dominion-provincial relations in the fields of taxation and social services.

In the end, the Dominion would merge its health interests, once again, with a more powerful and better funded department--this time, in the new field of welfare--and would sign over health grants to the various provinces to aid them in following their own inclinations in the provision of care for their citizens. This was not entirely an abandonment of the promises the Dominion had made when it established its first Department of Health in 1919. Conditions had changed--partly because medical technology had made great inroads into the problems of venereal disease, tuberculosis, infant and maternal mortality and possibly even mental illness by the end of World War II--and partly because a definite increase in health knowledge to which the health department had contributed during its first quarter century of existence had demonstrated that many facets of ill health were due not to lack of medical care but to lack of resources on the part of the individual to guarantee an adequate standard of personal welfare.

Predictably, the new call for reform ran head on into that old bogey, the British North America Act. At the beginning of the Depression, its definition of provincial rights regarding health was still treated as a sort of national shrine. Before any thought should seriously be given to "breaking" the Act, one Member of Parliament maintained that "[we] must first teach the people to live in a healthy state."[29] But by the end of the decade it was clearly established that instruction was not enough. As one critic remarked about the renewed campaign for education introduced by the Department in 1938, there was little use in instructing people how to cook food they did not have.[30] The usual defence raised against this type of criticism was that for the Department to do any more would be an infringement on provincial rights.

It might have been easier to resolve this issue had provincial rights been easily defined. Dominion and provincial representatives spent long hours all during the 1930s trying to arrive at a mutually satisfactory division of health duties.[31] The fact was that, despite ten years of Departmental existence, Canada did not enter the Depression with fixed designations regarding responsibility for the various aspects of public health. There was, therefore, no solid base on which reform could develop. Although at least one writer felt that lack of old traditions gave Canada a golden opportunity to establish modern and thorough-going measures,[32] another pointed out that uneasiness over provincial rights did not allow for "the sort of situation that breeds leadership and a progressive policy."[33] The provinces themselves could not always be trusted to act in a predictable manner. R. B. Bennett accused them of inconstancy: "health policies seem to have an amazing attraction for provinces at one stage and to arouse an amazing dislike at another."[34] But Bennett himself gave a description of the duties of the federal health department which was at odds with the views held by those who had called for and who had effected its original establishment. He argued that the federal Department of Health had not come into being to take on any progressive reforms. "It was rather to be a clearing house through which the information obtained in worldwide activity might be made available to the various provinces to assist them in discharging their duties." If the provinces were now too impoverished to act on Departmental advice, that was their own look-out.[35] His definition of Departmental duties denied the original spirit in which the Department had been established. The net result of the stand-off was that "[no] federal government and no provincial government has recognized any plan for the provision of medical service of any kind."[36] Even Bennett would at one point agree that, while the BNA Act should not be broken, it should be changed if that were the only way out of the stalemate.

In 1934, Bennett insisted that "there was no reason to believe that the provinces would not discharge their constitutional duties with respect to the health of their citizens,"[37] even though he admitted that the federal government had no power to compel such provincial diligence.[38] The next year, he would introduce his "new Deal" policies that assumed a more lenient reading of the BNA Act, at least regarding health, than he himself had supported before or would support after that time. Although some writers have charged that his temporary change of heart was simply a political lapse, convincing arguments have been raised to the contrary[39] and it has even been argued that the narrow reading of the BNA Act adhered to by the Privy Council was not only too stringent at the time but has led to long-lasting problems in Dominion-provincial relations up to the present.[40] Bennett was by no means the only Canadian who felt that something had to be done to make better provisions for the health of Canadians. The Liberal party also would discuss with the provinces possible reinterpretation of the Canadian constitution regarding matters of health[41] and the Regina Manifesto of the Co-operative Commonwealth Federation called in 1933 for new attempts at co-operation among Dominion, provincial and municipal authorities.[42] Not all critics bothered to couch their arguments in terms of the BNA Act, which, after all, had little enough to say about health. Besides, a whole slate of health problems had been recognized in the seventy years since Confederation. Although Heagerty, as chief Department spokesman, insisted that the Dominion had been assigned its fair share of duties under the Act and that it had, since that time, "assumed responsibility for such public health services as were exclusively Dominion or inter-provincial in aspect,"[43] the Canadian Medical Association countered that

> [because] of differences of opinion as to legal interpretation of the British North America Act with reference to public health, the provinces did assume certain responsibilities in public health and, up to the present, the Dominion authorities have shown no desire to interfere with what has been done.[44]

BNA Act or no, the CMA felt it was time the Department took a more active part. Besides, it argued, the idea that any health problem could ever be anything but inter-provincial in character was absurd. "There are no municipal, provincial or Dominion statutes which in any way alter the problem of dealing with a case of diabetes or infantile paralysis or cancer, in any part of Canada."[45] The pursuit of health and the treatment of disease were, or at least should be, the same from Vancouver to Halifax. The CMA represented an extreme position here. Other concerned parties saw good reason--administrative, if nothing else--for dividing health jurisdiction among the nine provinces.[46] At the same time, a federal Department was still needed to regulate uniformity and set standards.[47] Many of the bodies appearing before the Rowell-Sirois Commission envisioned just a happier and more fruitful marriage. Several organizations and some provinces argued neither for take-over nor for abandonment of the health field by the Dominion but for acceptance by it of the administration of certain nation-wide problems and the funding of others to be handled at the provincial level.[48]

The idea of federal grants-in-aid was hardly a new one. The Department of Health had, after all, been set up in 1919 partly to administer just such a grant for the combating of venereal disease.

Neither was the argument often raised against further use of grants during the Depression--that the Dominion would be relinquishing direction over the use of funds the public had paid out in taxes in good faith that they would be properly administered--a particularly good one. Similar grants-in-aid to the provinces for education, unemployment relief and old age pensions had given the Dominion some control over provincial jurisdictions and how they spent the money.[49] By mid-Depression, the Department was seriously discussing with the provinces re-establishment of grants for venereal disease[50] and establishment of new ones for health insurance[51] and tuberculosis.[52] But this renewed promise of federal funding was not simply to stand on its own, it was to be tied to attempts to achieve definite reform of the Canadian health system. There can be no doubt that it was the rigors of the Depression which, as Charlotte Whitton said, "dealt, ruthlessly and cruelly, with the Canadian's superb and simple confidence in his [sic] own destiny,"[53] that brought about the new surge for meaningful and lasting reform. Reformers frequently spoke of the effects of the Depression and the health of the people in the same sentence.[54] Frustration with the Department's failure to live up to expectations increased during the second half of the 1930s.[55] Canada was not the only country reassessing its commitment to the well-being of its citizens. The two nations to which Canada traditionally looked for comradeship, Great Britain and the United States, were also spurred to reassessment by the Depression.[56] Canada's first inclination was to look to Britain, not only the mother country but one that had already introduced some social security measures. But, as the Beveridge report indicated, reform was not to throw out old structures but merely to tamper with them.[57] Although some authorities felt a shift to more centralization, which would bring Canada closer to Britain in this matter, would be a progressive step,[58] others rejected the British proposals.[59] The Deputy Minister of Pensions and National Health sent a memorandum to his Minister explaining that the United States was the better model because of the shared federal system.[60] There were also similarities in economic and social conditions.[61] The United States had introduced some stop-gap social security measures to deal with the Depression and embarked on surveys to ascertain the extent of illness and injury plaguing the nation.[62] At least one reformer felt that Canada had some catching up to do.[63] But before Canada could embark on its own reforms, before it could establish joint co-operation to provide health care (an eventuality Whitton considered "an inevitable tug in the tide"[64]), it was necessary to ascertain just what was the state of Canadian health and just what were the shortcomings of the Canadian health care system. Such evaluations were necessary before any conclusions could be arrived at regarding the relative merits of state medicine and health insurance.[65] Otherwise, there was danger that the course chosen would once again prove inappropriate or, at least, insufficient.

W. J. Bell, the Deputy Minister of Health for Ontario, insisted in 1934 that

> [in] all our considerations involved in this subject of medical service, we have not yet arrived at any conclusions sufficiently definite to justify positive recommendations for governmental action. No matter what ultimate plan may be adopted, I am strongly of the opinion that that plan should be based on actuarial experience and deduction and positively not on emotionalism.[66]

By the end of the decade there were a number of studies in progress aimed at demonstrating that Canadians were experiencing serious problems and that the system, as currently set up, was incapable of ameliorating the situation. Others were in the planning stages before 1939 but would not reach completion until after the outbreak of war. There were also studies which originated solely from wartime concerns but which harked back to the problems of the Depression and looked forward to feared return of such circumstances. Most of the studies were not concerned merely with health but with social security or, a term frequently used towards the end of the war, reconstruction. In order of their dates of publication, the relevant major works are League for Social Reconstruction, *Social Planning for Canada* (1935); Leonard C. Marsh, *Health and Unemployment; some studies of their relationships* (1938); National Committee for Mental Hygiene (Canada), *Study of the Distribution of Medical Care and Public Health Services in Canada* (1939); R. D. Defries, ed., *The Development of Public Health in Canada* (1940); A. E. Grauer, *Public Health* (1940); Harry M. Cassidy, *Social Security and Reconstruction in Canada* (1943); Special Committee on Social Security, *Health Insurance, Report of the Advisory Committee on Health Insurance* (1943); Marsh, *Social Security for Canada* (1943); Charlotte Whitton, *The Dawn of Ampler Life* (1943); Health Study Bureau, *Review of Canada's Health Needs and Health Insurance Proposals* (1945); Cassidy, *Public Health and Welfare: The Postwar Problem in the Canadian Provinces* (1945); and Canada, Canadian Medical Procurement and Assignment Board, *Report of the National Health Survey* (Ottawa: King's Printer, 1945). In addition, there were articles in Canada's health and medical journals.

When the House of Commons Select Standing Committee on Industrial and International Relations had called in an expert at the end of the 1920s to comment on the state of the nation's health, he had apologized for his inability to supply such basic knowledge as the number of health professionals in the country and the cost of sickness to the economy. Without this information the adequacy of basic health facilities could only be speculated upon.[67] By the end of the Second World War, Canada would have a great deal of information on the extent of illness in the country over the past decade and a half. Some of the problems, notably nutrition, seemed to be closely tied to the economic depression[68] but many were the same old problems.[69] Venereal disease, tuberculosis and mental hygiene were still of concern. Perhaps of greatest importance was the infant mortality rate. The Health Study Bureau dolefully quoted Sir George Newman, a major figure in British health reform, who stated that "[infant] mortality is the most sensitive index of the progress of a nation."[70] Not only the Bureau concluded that Canada had therefore not progressed very far.[71] Two other types of problems were also under discussion--the degenerative diseases of middle age[72] and the poor standard of physical fitness among Canada's youth.[73]

The above reports and others also studied the problem of shortfall in the provision of care by health institutions already functioning. The fact of the matter was that, although provinces like Manitoba provided medical care for about one-fifth of its population by the middle of the Depression,[74] although other provinces made similar attempts at provision of care, and although the federal government tried to fill some of the gaps, the existing health system was under-utilized. Some hospitals had only about half of their beds in use and physicians, nurses and dentists all could do with more work than they were getting.[75] Some of this had to do with the maldistribution of health professionals across the Canadian population[76] but most of it was due to the inability on the part of the population to pay for care.[77] No matter what the cause, health professionals were concerned about lack of demand for their services. A study started in late 1929 as an assessment of nursing education in Canada, had shifted in focus by the time the research was completed in mid-1931. Good nursing education was one problem treated in the final report but another question to which it addressed itself was: "How shall the economic gap between the patient of moderate means and the qualified nurse be bridged to their mutual advantage?"[78] The Canadian Hospital Council asked similar questions,[79] as did the Canadian Medical Association. In 1934, the CMA released its "Report of the Committee on Economics." Presented before the annual meeting in Calgary in June, the report was duly marked on the title page with the proviso that "[it] is NOT to be interpreted as the opinion of the Canadian Medical Association on Health Insurance."[80] It reported that medical practice in 1932 was down to 63.5 percent of that of 1929 and that remunerative work only accounted for 50 percent of practice compared with 77.5 percent in 1929.[81] Almost half the doctors interviewed indicated that their income was insufficient to pay their expenses and provide the necessities of life.[82] The report supported health insurance but only if it were compulsory, thereby guaranteeing that doctors would be paid for the care of indigents, and only if the profession had considerable control of negotiations and administration.[83] If alleviation of the plight of the sick was argued as justification for new federal initiatives in health reform, alleviation of the plight of health professionals was pressed just as fervently. Indeed, sometimes the plight of the latter was allotted prior right for attention. As one member pressing in Parliament for health reform explained, "I bring the resolution before the house, first for the sake of the doctors, and, second, on behalf of the sick."[84] But before the Department could get on with matters, before it could act on all the data and opinion that others and itself were collecting, it had the general housekeeping of another war to deal with.

Although the new emergency at first relegated the demands for a general Canadian policy of health reform to the minor ranks,[85] it also called for an immediate stop-gap effort in the field of health. Need for citizens to support the war effort would lead to new Department activity in old fields and the addition of some new divisions. It would also, after the initial shock, encourage the Department to attempt to capitalize on all the information and all the momentum being gathered by introducing a scheme for long-term postwar provision of health care. Canadians went into the war, not only with no guarantee of medical care in times of trouble, but without even a standard for minimum wages and maximum hours for their labor.[86] War would grant them that elusive desire so longingly sought after during the years of Depression--steady work--but it would also ask for willingness to put in long hours, to rearrange old patterns of living and, for some, to offer up their lives.[87] The successful outcome of the war effort depended not only on an adequate standard of health for the present--thereby guaranteeing that people could live up to efforts they willingly promised--but also for the future--thereby guaranteeing that their willingness would be shored up by a feeling that they had something to fight for. As one of the propaganda pamphlets produced by the Department for overseas consumption insisted, echoing Senator Lougheed's statement of 1919:

> The war effort which demands the highest health standards of our fighters, workers and farmers and challenges the resources of our medical profession, has served only to drive home to Canadians the importance of planning in the field of health.[88]

Such planning would come later in the war. Stop-gap measures had prior rights. The first concern was that for the soundness of would-be soldiers.

As of 2 October 1941, 217,588 men had been examined for fitness to serve in the armed forces. Of these only fifty-six percent were found to be acceptable for training by the Department of National Defence. The situation was serious enough that a special interdepartmental committee consisting of representatives from the Departments of National Defence, Pensions and National Health and National War Services was set up to study the problem.[89] It was true that the rejections were fewer than had been the case for the Great War,[90] and that the medical examination had been stiffened.[91] It was also probably true that the first lot of would-be recruits most likely came from the pool of young single men chronically unemployed during the Depression--men not likely to be in top physical form.[92] The reasons for rejection did not indicate a degenerating Canadian race, rather an inability on the part of the populace to take care of itself and to obtain the medical care it needed. Hundreds of the rejected volunteers simply suffered from malnutrition[93] and a full twenty-three percent were turned down due to dental defects.[94] As was the case in the Great War,[95] many suffered from defects that could have been prevented or treated in childhood or that were amenable to corrective treatment as late as the date of the enlistment attempt. It was reported that more than half the rejections were due to hernia, eye conditions, respiratory troubles, ear problems, heart irregularities and urethritis (possibly a euphemism for gonorrhea).[96] According to the Minister of National Defence, one third of those who were accepted could not walk five miles.[97] Action was soon taken to lower the medical standard for enlistment[98] and dental work was provided free to increase the supply of eligible men[99] but none of this spoke well for twenty-five years of public health efforts.[100] One possibility was simply to provide facilities to bring marginal cases up to military standards, thereby decreasing the ranks of "the blue slip brigade," so named for the color of the rejection slips issued on medical grounds.[101] But this was really too cynical a suggestion. Major James W. Coldwell, reacting to a suggestion in the House that camps be set up for this purpose, deplored such cynicism.

> It struck me as a most serious indictment of the economic and social system, that we should allow these young men to deteriorate, to fall into decay in times of peace when we have no use for them, and then all of a sudden wish to recondition them to defend our institutions.[102]

That even men who had passed the physical examination were angry that it took a war to change their circumstances was indicated by an article in the November 1941 issue of *The Soldier*, entitled "Fat in War, Thin in Peace."[103] The more attractive alternative was to raise the standard of health for the population as a whole. It was pointed out in the House that had this been effected previously rejections now would not be so high.[104] The Minister of Pensions and National Health asked his administrative staff to come to what conclusions it could about the standard of health of Canadians by extrapolating from the rejection statistics. Although J. J. Heagerty, as usual put in charge of the study, warned that any inferences drawn could only be inaccurate, he concluded that Canada's health problems--military and civilian--were grounded in poor economic conditions. Good health depended on sheltering Canadians from changes in economic fortune, a good plan for the future.[105]

> Following the war, governments must plan for the welfare of the working classes and the control of unemployment. In this way only may physical defects and associated conditions be prevented.[106]

In the meantime, the Department had to see Canadian health through the current crisis.

Although the introduction of new initiatives in the Department was closely tied to the feeling of immediate national emergency, very little of the new work itself was strictly military in nature. The health of recruits, after all, became the responsibility of the Department of National Defence immediately upon enlistment.[107] Special war problems such as the provision of health facilities along the Alaska Highway,[108] did arise and the Department did have responsibility for air raid precautions assigned to it, on the grounds that the biggest problems following an air raid--injury, disruption of sanitation, loss of food and shelter, and epidemic disease--were akin to those following natural disasters, long accepted as being within the realm of Departmental authority. As in the case of the disasters they were classed with, the Department's activities regarding air raids were mostly precautionary and administrative,[109] concentrating on surveying such matters as the number of hospital beds that could be made available in an emergency.[110] The Department was also involved in two other activities that were strictly war-related. The Medical Procurement and Assignment Board was established in July 1942 to secure physicians for the armed forces while at the same time seeing to it that a sufficient number remained in civilian practice.[111] The other Departmental activity along this line was the supervising of a grant made to the Canadian Nurses' Association [hereinafter CNA] about the same time. The grant, originally for $250,000, was to be doled out in scholarships by the CNA, in attempts to attract more women into the hard-pressed nursing profession.[112] Increased demand on doctors, nurses and even hospitals was not simply due to military needs. Civilians were increasing their consumption of medical services at the same time. War prosperity brought a rise in the pregnancy rate and full employment allowed people to seek attention for problems they had put off for years.[113] But when it came time for the Department to tot up its war activities, only six of its divisions--Industrial Hygiene, Medical Investigation, Narcotics, Nutrition, Public Health Engineering and Quarantine, Immigration Medical and Sick Mariners Services--were considered to have undergone new emergency planning on account of the war, and most of them not to a very great extent.[114] The Department's role, rather, can be best summed up by a resolution passed by the Dominion Council of Health in October 1939:

> Whereas the successful prosecution of the war depends largely on the maximum use of all our resources;
> And whereas our most important resource is our people;
> And whereas a healthy citizenship insures to the State the maximum advantage in the present emergency;
> Therefore be it resolved that the highest possible level of good health must be maintained amongst our people and to this end it is imperative that all Health Departments--Federal, Provincial and Municipal--shall maintain the present standard of health services and, where deemed advisable, expand such services to take care of our present problems and any new ones which may arise from time to time.[115]

To hold up its end of the bargain, the Department would step up its activities along the old traditional lines, information and quarantine, and would once again supervise grants to other governments and agencies.

Nutrition, a new activity taken on by the Department at the end of the Depression in response to evidence of sinking nutritional standards, was not elevated to a regular division until 1941 and did not receive a regular appropriation of funds until 1942.[116] Up to that time, nutrition had been the responsibility of the Canadian Council on Nutrition, an adjunct of the Department. That body had mostly been concerned with the direction of four dietary surveys to study the food standards of Canadians.[117] It also studied the nutritional worth of foods,[118] especially in light of the new information on vitamins.[119] The Council continued to function after the establishment of the new division, but it was the Division of Nutrition Services that took over the active aspects of the nutritional campaign: inspecting the cafeterias of industrial plants, advising the general public, making expert opinion available to the Wartime Information Board and other departments of the federal government and conducting investigations and research into dietary and nutritional problems.[120] The Division churned out nutrition propaganda, alone and in tandem with other agencies.[121] It was claimed that, by the end of the war, Canadian dietary habits had changed significantly due to public education.[122] It is not immediately apparent how this could be so, unless jingoism was enough to spur Canadians into ameliorative action. A set of jingles composed for public release in 1942 included:

> The Wise Owl remarked with a hoot
> "We've still got the Axis to shoot
> You folks must be spry
> You can help if you try
> By eating, each day, Citrus Fruit."[123]

Admittedly, this is the least poetically clever of the lot. In reality, the problem in the war was not one of consumer obstinacy or ignorance but one of insufficient supply of the recommended necessary foodstuffs. A calculation of the amount of milk, cheese, fruit, vegetables, meat, butter and eggs needed to ensure proper nutrition ran up against figures on production that were so bad it was difficult to estimate how much more was needed. In the case of milk, a figure of twenty-three percent was settled upon as the needed increase in production.[124] Despite Departmental hopes for the efficiency of the Nutrition Services, Canada lagged behind both Britain and the United States when it came to the process of actually getting good food into the mouths of the citizenry.[125]

Industrial Hygiene was another division born of the reform surge at the end of the Depression but, like Nutrition, encouraged by the climate of war. Originally established in late 1938, it was seen as a natural extension of the well-established school medical inspection system.[126] The Dominion division would do surveys to uncover industrial health hazards and would pass the information on to the provinces which would then be expected to take action.[127] The Division barely got started, modelling its work after similar industrial hygiene efforts started in the United States in the mid-1930s,[128] when war brought it special duties. The most urgent problem was that of the extreme toxicity of chemicals used in the manufacture of explosives.[129] The manufacture of TNT carried particularly high hazards.[130] By 1941, calls were being made for expansion of the Division so it could take on further industrial health hazards[131] and it soon began to branch into examinations and recommendations for improvement of working conditions and medical care of all personnel involved in war industries.[132] In

1942-43, the Division launched a campaign of diagnosis for tuberculosis and venereal disease,[133] the latter particularly regarded as a threat to Canada's war effort.[134] The Division underwent a considerable expansion in 1945, not so much with a view to keeping up with war work but with "the great era of industrial production which . . . will follow post-war adjustments."[135]

All the drug-related divisions would face increases in work due to the war. Narcotics, by far the most romantic division in the Department, in charge of an activity that always existed in the penumbra of the underworld, was under the charge of Colonel C.H.L. Sharman, described in the House as "a bombast"[136] and who was the sort of man who would use a term like "the outbreak of Peace."[137] Its most plebeian wartime activities involved screening would-be medical corps recruits for possible addicts or traffickers[138] and sharing out the ever less than adequate supplies of narcotics between civilian medical practice and the military.[139] However, the war dried up illegal as well as putting pressure on legal supplies and the Division had also to deal with an increase in criminal attempts to lay hands on legal supplies whether through robbery or trickery on the part of traffickers or addicts, or dishonesty on the part of doctors or pharmacists.[140] Despite cloak and dagger methods and impugnments of the ability of the chief and his staff--they were accused of not being able to tell the difference between cocaine and Five Roses Flour[141]--it would seem that the Division did at least an adequate job of doling out and safeguarding Canada's narcotic supplies during the war.

Food and Drugs had also to make some changes due to the war. While the fact that less food was imported took some of the pressure off the food inspectors,[142] they had now to decide on adjustments of standards for foodstuffs to meet wartime conditions.[143] The Drugs side was even more active. Early in the war the inaccessibility of some ingredients caused drug prices to rise.[144] Within another year, some ingredients were simply impossible to get.[145] This had two results. First, the Division seriously reassessed Canadian pharmacopeial standards in search of substitutes[146] and, second, Canadian suppliers began to look for homegrown alternatives.[147] At the same time as the Division had to evaluate the worth of the proposed substitutions, it also had to deal with a change in the Food and Drugs Act making more preparations available by prescription only.[148] The Division also co-ordinated chemical warfare research for the Department of National Defence.[149] The Proprietary and Patent Medicine Division, on the other hand, experienced a reduction in workload due to the war. There was the problem of manufacturers' substitutions due to the scarcity of ingredients but this was bypassed by allowing manufacturers to make substitutions for the duration of the war without procuring a new registration number, providing the substitutions were suitable.[150] But another war-related shortage--that of paper--led to a definite lessening in the Division's duties. Lack of paper meant that manufacturers produced fewer circulars advertising their preparations.[151] Vigilance over false advertising was one of the Division's basic activities and this was now sharply curtailed.[152] The Laboratory of Hygiene continued in its former peacetime functions of testing drugs and possibly contaminated foodstuffs for the above divisions and Public Health Engineering.[153] By 1943, it was undergoing expansion so that it could standardize and control the manufacture of biological products needed by the military and added a new Virus Subsection to take advantage of the new findings made in the field of filterable viruses.[154] The next year it undertook the assay of penicillin, in an attempt to keep up standards for the wonder drug being developed so rapidly.[155] About the same time it would also start doing work for the newly re-established division for the control of venereal disease.[156]

The divisions dealing with the spread of disease also had special duties imposed by the national emergency. In addition to its usual duties of guaranteeing sanitation on transportation lines, administering the Public Works Health Act and supervising the wholesomeness of Canada's seafood, Public Health Engineering at first found itself saddled with the development of air raid precautions.[157] By 1942, it was in charge of the design and maintenance of sanitation requirements for all armed forces, concentration, refugee and Japanese work camps.[158] As construction continued, the Division's work doubled from one year to the next.[159] At the same time, the Division had to cover all its old duties,[160] sometimes increased themselves--especially the inspection of transportation lines, hard-pressed due to troop movements.[161] By the end of the war, Public Health Engineering had managed to establish itself as one of the more active divisions and was beginning to look ahead into such matters as the effect of poor housing on public health.[162] While the immigration section of the Division of Quarantine, Immigration Medical and Sick Mariners Services underwent a distinct decrease in activities due to the war, the only regular supply of immigrants being from Great Britain[163] and Newfoundland (the latter drawn to the mainland by war work[164]), the two other sections saw their work increased. Not only the increase in shipping,[165] but the suspension of radio pratique[166] meant that Quarantine's officers had more ships to inspect. Increased shipping also meant more work for the staff of Sick Mariners Services[167] and occupation of many European countries meant that Canada had to make provisions for chronically ill sailors who could not, under the circumstances, be sent home.[168] The Division of Epidemiology did not survive past 1939,[169] no doubt due as much to the fact that it had failed to produce convincing evidence that the communicable diseases it was studying were a threat to Canadian health, as due to war conditions.

Other divisions did not fare well during the war. The Medical Investigation Division, although it took over the examination of would-be merchant seamen,[170] never managed otherwise to expand beyond investigating and examining the civil service. Its main task changed from policing malingering during the Depression to attempting to keep government employees, mostly in Ottawa, well and on the job. The biggest threats during this period were successive epidemics of influenza in 1940-41, 1941-42 and late 1943.[171] By the end of the war, the Division was taking the forefront in two new health activities by checking its employees for tuberculosis[172] and venereal disease.[173] Although the Division undertook a much heavier workload during the war, it did not manage to expand its staff by more than half.[174] Publicity and Health Education did even less well. The annual report of the division posed the dilemma it saw itself faced with.

> Wartime stress and strain has placed increased responsibility on the shoulders of those whose duty it is to acquaint the people with the value of health, for at no time in our history has the health of every man, woman and child been of such paramount importance. On the other hand, financial outlays for the weapons of actual warfare take first place in a nation engaged in total war and the forces of health education must achieve their aim of increased service to the people without increasing their expenditures.[175]

Already this early in the war, the Division had to abandon all hopes of expanding into the production of motion pictures and to stop exhibiting health propaganda at exhibitions, fairs and conventions. Instead, it concentrated on the cheaper media of the *National Health Review*, radio notes, press releases, posters and the distribution of health literature.[176] The Health League of Canada also made some contribution by expanding into other health fields than venereal disease.[177] But by 1942, the Department's distribution of health literature was cut back[178] and by 1944, the Division was discontinued at least for the duration of the war.

Although it managed to stay in existence, the Child and Maternal Hygiene Division also receded to the background during the war. When war was declared, the Division had just started catching up in revising the literature that became obsolete during its four year hiatus.[179] Early in the war, calls again came for its abolition on the grounds of uselessness. It was suggested that its "personnel be transferred to some other branch until they die, when we would be rid of them."[180] The government wavered but, in the end, kept the Division on.[181] As before, it specialized in the production and dissemination of literature. Infant and maternal mortality statistics would undergo significant improvement during the war but this had less to do with propaganda than with improvements in living conditions and in medical technology.[182]

The two divisions which can be seen as definite positive steps towards solving long-term problems were involved in two activities perceived as closely related to the war effort. The Department of Health had been established in 1919 partly to deal with venereal disease. With the Depression, federal commitment in this area waned--it did not seem like the health problem most worthy of concern. But, just as the Great War sparked the original reform, World War II again focused attention on these destructive diseases of the reproductive system. Once again, examination of recruits demonstrated an unacceptably high morbidity rate for both syphilis and gonorrhea. The Departmental reports had carried some spotty information on provincial activities in the field during the 1930s[183] but it was not until the very end of the decade that the Medical Investigation Division attempted to come to some conclusions about the long-term effects of the disease by studying the records of about twenty thousand pensioners of World War I.[184] The curtailment of the federal VD grants in 1932, after a final flurry of conferences and public talks,[185] was criticized severely at the time, not least of all because economic conditions led sufferers to turn from private doctors to public clinics for treatment of the conditions.[186] Criticism continued throughout the decade[187] but, although the Department continued to take an interest in VD and answered many requests for information on the topic,[188] federal funding for the clinics was not again discussed seriously until 1938.[189] By 1940, the Department administered a grant of fifty thousand dollars a year to aid the provinces in buying arsenical drugs for the treatment of syphilis.[190] The war brought civilian and military co-operation in such matters as joint conferences[191] and, in 1943, the federal government re-established a Division of Venereal Disease Control. The reasons given for the re-establishment echoed those of 1919.

> Mounting venereal disease casualties, heavy costs and preventable hospitalization in the Armed Forces stationed in the nation could not be ignored. Coincident rising public interest set a propitious stage for the expeditious inauguration of venereal disease control measures throughout Canada.[192]

The Division was to produce and distribute information, to liaise with the military and provincial authorities, help the Dominion Bureau of Statistics gather data and to administer the re-instituted provincial grants.[193] Although brought back to life by the war emergency, the VD Division was also an answer to the problems of peace: once again Canada expected an epidemic of venereal disease to follow the cessation of hostilities and the demobilization of the troops.[194]

The Division of Physical Fitness was the other division growing out of concern for both soldiers and civilians. Concern for the physical fitness of young Canadian males was a side-issue of the unemployment situation of the 1930s[195] but, although there was enough evidence and opinion to bring about consideration of official action, nothing was really done until 1943 by which time the link between physical fitness and preparedness for war could be forged.[196] Even then, the course of action chosen was not a very aggressive one. The Division was to administer a grant to the provinces and liaise with all interested parties.[197] By 1945, all provinces but Ontario, Quebec and New Brunswick had signed agreements[198] but, due to lack of funds,[199] nothing much had been accomplished by the time peace was declared.

None of these divisions, as popular and valuable as their work might have been, was going, however, to be able to solve the problems that had existed before the war and that were expected to return after the war. Epidemics[200] were not the only health problem expected to take on prime importance with the coming of peace. The Canadian public feared that a return to peace would mean a return to want.[201] Reformers frequently stated the case in print.[202] All political parties considered the implications.[203] It was particularly feared that any return to depressed economic circumstances would spell political unrest, even revolution.[204] After all, economic ruin had led even doctors to stage a sort of strike in Winnipeg in the mid-1930s.[205] There was a deep concern that the war should have more positive results than just the defeat of fascism. Canadians had to feel they were fighting for a better future.[206] The nation was not alone in this desire. As Henry E. Sigerist, an internationally-known health reformer remarked before a meeting of the Health League of Canada in Ottawa, 10 February 1944:

> Social security is undoubtedly the major domestic war aim of every country that has not yet solved the problem. It is also implicitly included in the Atlantic Charter. *Freedom from want* will remain an empty promise unless concrete steps are taken now for its realization.[207]

The federal Department started discussing strategy for guaranteeing its part of social security almost at the outbreak of war. In June 1941, the Dominion Council of Health played host to a conference regarding "Post-War Public Health and Medical Services."[208] The one big reform that most appealed, in the sense of providing what was wanted with the least reorganization of existing facilities or reinterpretation of the privileges and duties of the various governments and professions, was health insurance. The scheme that had already failed in two provinces would be attempted anew by the federal government.

Health insurance would also fail to find acceptance as a federal measure. Since first introduced in Germany in 1883, health insurance--either entirely or principally compulsory--had been legislated in twenty-five countries by 1936.[209] Although Canada looked at as many of these plans as it could find information for, its models were Great Britain, where a government health plan had functioned since 1911[210] and the United States which, like Canada, failed to get one off the planning table.[211] Discussed frequently in the House of Commons and by various health authorities throughout the Depression, supported by doctors and left-wing political groups alike,[212] health insurance was to be a compromise between the current individual doctor-patient system--perceived as malfunctioning--and state medicine--perceived as too radical.[213] Although rooted in the economic troubles of the 1930s, it took the war to make plans for health insurance (along with other social security proposals) feasible. As one historian has remarked, "the war altered everything. Deficits in peacetime were just acceptable; deficits in wartime, however, were patriotic."[214] Under the War Measures Act, proclaimed 1 September 1939, the Dominion acquired greatly strengthened powers.[215] Contemplation of social security during the war, then, did not mean figuring out how to obtain more power but merely haggling over what powers to relinquish.[216] Unfortunately for those strongly attracted to health insurance, power to legislate it would be something the Dominion would be forced to renounce.

The natural choice as far as an employee to head the Department's investigation of health insurance was John Joseph Heagerty. Heagerty had originally started working for the federal government as a bacteriologist at Quebec City in 1911 and then as quarantine officer consecutively at Grosse Isle, Quebec and Saint John, New Brunswick. When the Department of Health was established in 1919, he was selected as chief of the Division of Venereal Disease Control. He rose through the ranks to be Executive Assistant to the Department in 1928 and Director of Public Health Services in 1938.[217] If the files of the Department demonstrate that he was an extremely hard worker, they also show that he was opinionated, vain, prudish, naive when it came to faith in the self-abnegation of doctors, occasionally waspish and, as a rule, a man of diligence rather than imagination. He had obviously had the confidence of the first Deputy Minister, John A. Amyot. After Amyot retired due to serious illness in 1932,[218] and was replaced by R. E. Wodehouse as Deputy Minister, Heagerty's rise probably had less to do with support from his superior than with the fact that he was now operating in something of a vacuum. Although Wodehouse had had good public health training from the University of Toronto, had years of experience as local, then district, health officer in Fort William and had served for the past thirteen years as the secretary of the Canadian Tuberculosis Association,[219] he does not seem to have been an innovative Deputy Minister.[220] In 1944, Wodehouse was replaced by Brock Chisholm, a psychiatrist who was definitely more active in Department affairs and especially in publicity. Unfortunately, this penchant for publicity led him to make public statements destined to bring down upon his head the ire of significant parts of the Canadian population. He counselled against allowing children to believe in such "falsehoods" as Santa Claus and fairies and he insisted that the only way to adjust recruits properly to army life was to weaken the influence of women, especially mothers, whom he considered a liability in wartime because they "are not oriented toward society, they are oriented toward men." When he resigned to take a United Nations post only two years after becoming Deputy Minister, he was referred to by the Toronto *Daily Star* as the Santa Claus Foe.[221]

Neither was Heagerty faced by a procession of strong ministers. Aside from Newton J. Rowell, the first Minister, none of the five men who held the post throughout the 1920s made a significant mark.[222]

Neither Murray MacLaren, in office from 1930 to 1934, nor Donald Sutherland, who replaced him for less than a year after that, managed to hold back the budget cuts of the Depression. The appointment of Charles G. Power as Minister of Pensions and National Health in 1935 was a distinct departure from accepted practice. Canada has had a tradition at both the federal and provincial levels of government, requiring not only that deputy ministers and almost all senior officials in health departments be medically qualified but that the same apply to ministers.[223] Power was not only not a doctor, neither had he any particular lay experience in the health field before his appointment as minister.[224] He had often to defend himself on this ground before the House of Commons.[225] Power was an unusual health minister for another reason: he seems to have been a man of some ability, held back from better things largely because of a drinking problem. A cabinet shuffle brought Ian Mackenzie to the post at the beginning of the war. Mackenzie had not distinguished himself previously as Minister of National Defence but he would take an active interest in the activities of his new Department.[226] It was he who pressed for the establishment of health insurance as part of the government's promised social security package.

Heagerty, who had prepared memoranda on health insurance as early as 1931,[227] was given leave from his position as Director of Public Health Services to serve full-time as head of a committee to study health insurance.[228] The establishment of the Advisory Committee on Health Insurance on 5 February 1942 was the most solid step the Department had taken in this field since it began studying health insurance in 1928.[229] A draft act was ready for confidential discussion at the regular meeting of the Dominion Council of Health in March 1942[230] but the full Report of the Advisory Committee on Health Insurance was not released until 16 March 1943.[231] The Report ran to over five hundred pages and contained not only a draft bill but surveys of the history of health insurance in other countries, of currently functioning health insurance schemes, of Canadian public health agencies and the state of the public's health, an estimate of cost and fourteen submissions commissioned by the Committee from various organizations.[232] In tandem with the proposed health insurance bill was a bill to establish a National Council for Physical Fitness and it was this bill more than the major one that really demonstrated what reformers wanted for Canada in the field of public health. Heagerty, in a glowing speech before the House of Commons Committee on Social Security, painted a lovely picture of Canadian health prospects possible under compulsory health insurance and a national fitness campaign.

> When the ministers of health met here October last I called to their attention a moving picture that was put on here in Canada by Russia. Perhaps many of you have seen that picture. It was a very beautiful thing. I have no doubt they selected the finest athletes, both male and female, in Russia, and they marched through Red Square. You will remember that some of them were playing football, mothers marched with their children on their shoulders, and others were magnificent skaters; there were boxers; there were bar bell artists, dancers. I have never seen a more beautiful spectacle, and of course all of us asked ourselves why we could not get something of a similar nature in Canada.[233]

Health insurance would remove one major obstacle to Canadian fitness--it would allow all citizens to obtain treatment in time of physical need. It would also provide funds so that provinces could upgrade their activities in public health and preventive work and services.[234] But it was not to be. After several years of study and fewer of negotiation, the federal health insurance package failed to gain acceptance at the Dominion-Provincial Conference of 1945-46.

The health reform proposals were based on the idea that there was a fixed pool of ill health in the community which could be measured by adding up all health expenditures in the country in a recent year. A. E. Grauer had come up with the figure of $253,113,671, or $24.69 per capita, for the year 1931 when he was preparing his report for the Rowell-Sirois Commission. The Heagerty committee settled on a sum very close to this: $250,000,000 or $21.60 per person. One hundred million dollars of the needed funds were to come from individual contributions, an equal amount from Dominion general revenues and the last fifty million dollars from Dominion income tax. The $21.60 allotment per person per year was to cover doctors' fees, hospital care, nursing services, dental care, pharmaceuticals and laboratory services. General practitioner service was allowed six dollars per year and other doctors' services--in the form of consultant, specialist or surgical attention--were allowed an additional $3.50. This meant that the medical profession was to receive nearly forty-five percent of the funds. Dentists, by comparison, were allowed only $3.60 and all nursing services only $1.75 per annum. All laboratory services were expected to cost no more than sixty cents and hospitalization was to be provided for less than four dollars a year a person. In addition to the funds to enact these health insurance proposals, there was a planning and organization grant to aid the individual provinces in introducing their separate but identical schemes and in training necessary personnel; health grants for the fields of tuberculosis, mental health, venereal disease, physical fitness, special investigations in public health and professional training for physicians, engineers, nurses and sanitary inspectors; and financial assistance for the construction of hospitals. To obtain Dominion money, each province had to make promises and cash commitments of its own. It was an ambitious scheme--too ambitious.[235]

Partly the scheme failed because of its own defects. Actuarially, its calculations were open to attack. Affirmations that "public health is dirt cheap"[236] were simply not true. As one study pointed out, insurance allowed people to make greater demands on existing facilities and this brought ever increasing costs.[237] This was not a matter of patients or doctors abusing the system, as some feared,[238] simply a matter of people being able to do precisely what the plan would be established for them to do--to have their physical complaints administered to. If enacted, the plan would also have led to stress of epidemic proportions on existing facilities. Although the whole package included grants to help the provinces expand their facilities,[239] there would, of necessity, be a time lag before this could be performed. In the meantime, the call on hospitals and professionals would be overwhelming.[240] One official estimated that three times the number of dentists would be needed immediately.[241] The scheme could also be attacked for leaning too far in favor of doctors. Physicians were to receive a portion of the premiums that was out of all proportion with actual health care costs.

The medical profession was involved in the government study from the first. The Canadian Medical Association had started its own studies into health insurance in 1929.[242] The Depression had increased the profession's interest in what might prove to be the answer to their acute problems of getting payment for their services. It is possible that the war also added to their fears. Not only was there the spectre of another post-war depression, there was the more tangible possibility that medical officers would return from the war only to find their patients dispersed and their practices defunct, as had happened at the end of World War I.[243] Canadians certainly had no objection to doctors being guaranteed a living wage. A traditionally rather radical member of the House of Commons stressed the need for action because "first, there is the urgent need of those who are ill, and, second, the doctor."[244] A propaganda pamphlet on health insurance circulated to the armed forces asked if it were fair for doctors to provide service with little or no hope of remuneration.[245] But, although doctors might want some government support, they strongly feared concomitant government control of their traditionally independent profession.[246] They feared that, since politicians represented the consumers of medical service, there would be a tendency on the part of these politicians to ignore the rights of the producers (the doctors) in order to please their constituents.[247] Therefore, although they were willing in the end to let the government take over all financial aspects, they still wanted control not only over the types of services to be provided but also over the fees to be paid.[248] The Department had a long tradition of close co-operation with the Canadian Medical Association. This is not to say the relationship was not without strife. For example, when the CMA asked the Department in 1929 if the latter cared to join the profession in an investigation of health insurance rather than vice versa, Heagerty remarked that they were endeavoring "to run away with the whole show."[249]

The Department would not follow the advice of one Member of Parliament that the doctors should be encouraged to formulate a scheme of their own liking, thereby avoiding any refusal on their part to participate.[250] But Wodehouse would assure the CMA--of which (as was also the case with the Canadian Public Health Association[251]) he was a member of the executive[252]--that the officials of the Department "do our utmost to maintain at every turn the interests of the practitioners of Canada as well as organized medicine."[253] The Department did not act so closely with other bodies on legislation respecting them. When suggestions were put that an advisory board of representatives from the relevant industries be established to advise the Department on legislation regarding the manufacture of food and drugs, Heagerty was adamantly opposed. "It does not appear logical that the Government of Canada should hand over the privilege of making laws to a group of individuals who have their own ends to serve."[254] Now, the Department was collaborating closely with the Canadian Medical Association--so closely, in fact, that the nose of the College of Physicians and Surgeons of Canada was rather put out of joint[255]--on a matter that certainly could serve the profession's ends.[256] The CMA was called in, confidentially, to discuss health insurance[257] even before the first draft was taken before the DCH. By 1942, the liaison was official and public: Heagerty announced in the *CMAJ* that the Department would co-operate closely with the CMA's Committee of Seven.[258] As before, negotiations did not always go smoothly. At one point, the Committee set up its own headquarters in the Chateau Laurier and demanded that Heagerty wait upon them rather than vice versa.[259] And the CMA was not always constant in its support of the proposed measures. In 1943, the CMA Council approved health insurance in principle[260] and the support of its past president Gordon S. Fahrni was lauded in the House of Commons.[261] After the Dominion lost its jurisdictional dispute with the provinces, however, and the profession faced negotiation with nine separate political bodies, the CMA withdrew its support.[262] In 1976, Fahrni would devote part of his autobiography to a denunciation of the "socialistic encroachment on health care, over the past few decades" and culminating in the federal medicare bill of 1968[263]--the bill that finally brought in health insurance.

The doctors were not the only ones to take a conservative stand when it came to the health insurance bill. The Catholic church feared for its effect on personal initiative,[264] as did the Progressive Conservative party.[265] Even Heagerty, himself, feared that health services might suffer under too much government control. He particularly worried that administrators might be appointed on the grounds of political favoritism rather than ability.[266] But the real defeat of the Department's health insurance proposals came at the hands of the British North America Act. By June 1944, the study was wrapped up and in the hands of all the provincial governments.[267] Federal officials knew from the first that upcoming Dominion-provincial conferences would be crucial to its acceptance or rejection. The Dominion itself announced at a similar conference in 1933 that "[the] entire attitude of the Dominion on the subject of health insurance is that the mandatory terms of the British North America Act place jurisdiction on the provinces."[268] The Rowell-Sirois report decided that "public health insurance, if established, should . . . be a Provincial responsibility."[269] The problem with this decision was that it meant that the health of Canadians would depend "too largely" on the economic condition of their province.[270] There were arguments in favor of keeping jurisdiction over health in provincial hands. Most importantly, it would allow provinces like Alberta and Saskatchewan to build on their existing programs rather than wait for the rest of the country to catch up.[271] It was also possible that provinces might go ahead with health insurance themselves. British Columbia and Alberta already had bills on the books and Saskatchewan passed a health insurance act in 1944.[272] But there were also serious problems with relying on provincial initiative in this field. The provinces simply did not have the money to proceed. To raise revenue, they had only direct taxation to rely on.[273] Too much activity in that field might lead to businesses and individuals fleeing the ambitious province for residence elsewhere.[274] The natural source for funds to provide health and other social services was the Dominion treasury,[275] but while federal grants-in-aid to provinces were not a new suggestion for Canada,[276] they had never been popular as far as federal governments were concerned. At least they were not popular unless the provinces would agree to relinquish some jurisdiction which in turn was not popular with the provinces or the advocates of provincial rights.[277] It had been suggested that one way around this situation was to appoint medical experts to the federal Department who were so overwhelmingly respected as leaders in the field that the provinces would, by sheer force of argument, fall into line.[278] In this way there would be no need for the provinces to relinquish jurisdiction as their use of their powers would be controlled by minds attached to the Dominion. More realistically, the Department set about investigating the legality of the BNA Act in matters of health.[279] Would it be possible for the federal government to take over? The answer was firm: without amendment to the Act, provinces could not be forced to participate, they must be persuaded.[280] There was a reason other than reluctance to dole out money over which it had no control that dampened the Dominion's fires. The federal government seriously debated whether it could afford the scheme itself.[281] Mackenzie King admitted that "frankly I did not think the Treasury could stand it."[282]

The BNA Act might have been overcome[283] and the money found had conditions been different. But the truth of the matter was that other reforms took precedence over health insurance. Unemployment insurance and family allowances simply seemed more pressing and, in a way, this did show a healthy flight from the old illness-causes-poverty dogma. It could be argued that, whereas health insurance would not improve prosperity--except perhaps for those employed by the health care industry--a system of welfare payments (including unemployment benefits and family allowances) would improve the standard of health.[284] As the Director of the Department of Public Health of Montreal pointed out in a speech before the Health League of Canada in Toronto in October 1942: "One of the reasons for the relatively low level of public health in Canada is certainly that there are altogether too many families with insufficient incomes."[285] Although it was still true that a serious illness, especially a chronic one, could wreck even the most carefully planned and comfortably cushioned budget,[286] even Heagerty stated in 1933 that "[personally], I would prefer to see unemployment insurance established before health insurance."[287] With the end of the war, there was another factor that militated in favor of relegating health insurance to the tail end of social security measures. For some years, the Soviet Union had been held up as a model for state-run health care. The Russian system was lauded in the House of Commons,[288] health literature,[289] and government propaganda.[290] Pressure for state medicine along Russian lines was advanced not only in Canada[291] but in other allied countries.[292] But just as expressed adulation for the Hitler Youth Movement tended to disappear from health literature with declaration of war,[293] support for anything Russian disappeared with the signing of peace. The fortunes of the CCF party rose and fell with the shifts in public opinion. Always eager to avoid being identified with leftist "political extremists and faddists,"[294] and adherent to a fairly mild form of socialism itself,[295] the party could be seen as a distinct threat to the dominant Liberal party in 1944[296] but a much lesser one with the advent of the Cold War a year later.[297] Other changes in the situation followed the end of the war. When the expected depression failed to materialize, doctors became ever less interested in health insurance.[298] Even government-professional negotiations had altered. From now on things would not be handled directly between publicly-employed doctor and privately-employed doctor but through the representations of lawyers and economists.[299] Heagerty, himself, retired in December 1945, before the health insurance proposals went down to final defeat. He was kept on as emeritus Special Assistant to the Deputy Minister of Health but died less than two months later.[300] Before his death his Department had already been altered to that of National Health and Welfare and his last great effort, Health Insurance Studies, enshrined as a division within that department.

The Department of National Health and Welfare came into being in July 1944.[301] Only outcry in the House and on the part of the health and medical professions kept the term "Health" in the title of a Department which was originally to be called only Social Welfare.[302] But retention of the term and, indeed, honoring it with precedence, did not guarantee new initiatives in the health field.[303] It tidied up some old matters[304] and added some new ones but the *status quo* was guaranteed.[305] The Department was to be divided into two branches. The Health Branch took over the already established Divisions of Food and Drugs, Narcotics, Proprietary or Patent Medicine, Public Health Engineering, Child and Maternal Hygiene, Industrial Hygiene, Medical Investigation, Venereal Disease Control and Nutrition as well as Quarantine, Immigration Medical Services and Treatment of Sick Mariners and the Laboratory of Hygiene. New arms were also added in the form of Advertising and Labels, Blindness Control, Civil Service Health, Dental Health, Hospital Design, Mental Health and Tuberculosis Control Divisions, plus the Directorate of Health Insurance Studies and the Indian Health Services. The Welfare Branch was responsible for the Family Allowances Division and Old Age Pensions, Physical Fitness and the Women's Voluntary Services Division. A third co-ordinating branch, Administration, was to handle the book work for both.[306] The new minister was Brooke Claxton, a lawyer. Although the Department would continue to work in the health field, welfare early took the lead. Even the federal government's crowning glory in the health field, the national health insurance plan which covered virtually all Canadians by 1972, can be seen as an abdication, an attempt finally to shift the responsibility to provincial shoulders. Recent threats on the part of the federal government to pull out of--at least to lessen its financial commitment to--"medicare" only supports this suspicion. The fact of the matter is that it is welfare concerns that followed World War II just as health concerns followed World War I and it is welfare concerns that have dominated the post-war development of the Department. As one lesser official of National Health and Welfare remarked in 1978, in recent years, "doctors have done very badly" within the administration of the Department.[307] The Department is now controlled by economists and sociologists and the stress is very much on welfare. In some ways, this can be seen as a blow in favor of public health in Canada. So much of the federal health activity in the Department's first twenty-five years centred on the production of information that private citizens were expected to put to practice themselves. Welfare provisions at last allow at least the possibility for more people to afford to act on this information. They also aim at providing a standard of living high enough to avoid other problems. The shift from health to welfare is not necessarily a betrayal of the promises of 1919 but rather an attempt at a different sort of solution.

NOTES

[1] PAC, DCH Minutes, 37th meeting, 6-7 Dec. 1938, p. 1.

[2] Commons, *Debates*, 1938, p. 1067.

[3] Stewart Crysdale, *The Industrial Struggle and Protestant Ethics in Canada* (Toronto: Ryerson Press, 1961), pp. xii-xiii.

[4] PAC, RG 29, vol. 1062 (file 502-1-1, part 2) Clipping from Toronto *Daily Star*, 28 Nov. 1933.

[5] PAC, RG 29, vol. 1062 (file 502-1-1, part 4) Letter from Mrs. H. LaRose, Secretary of the Buffalo Plain Home Makers Club, Windthorst, Sask. to W.L.M. King, 20 Nov. 1935.

[6] PAC, RG 29, vol. 1062 (file 502-1-1, part 2) Clipping from Toronto *Daily Star*, 28 Nov. 1933.

[7] Cassidy, *Public Health and Welfare Organization in Canada*, p. 5.

[8] "Medical Relief," p. 187.

[9] PAC, RG 29, vol. 1062 (file 502-1-1, part 3) Letter, Wodehouse to T. C. Routley, 28 Jan. 1935 asking him to explain the statement which appeared in that month's *CMAJ*.

[10] For examples, see Commons, *Debates*, 1928, pp. 561 and 1493 (A. A. Heaps); 1931, p. 996 (J. P. Howden); 1932, p. 1326 (Howden); 1934, p. 499 (H. E. Spencer); 1935, p. 172 (Spencer); 1938, p. 1067 (Daniel McIvor); 1939, p. 1573 (McIvor).

[11] H. R. Fleming, *ibid*, 1938, pp. 1080-4.

[12] PAC, DCH Minutes, 41st meeting, 12-14 June 1941, p. 19, letter read by Wodehouse.

[13] *Ibid.*, p. 17.

[14] *Ibid.*, p. 18.

[15] See Chapter 6.

[16] Senate, *Debates*, 1919, p. 288.

[17] Commons, *Debates*, 1930, p. 223.

[18] PAC, DCH Minutes, 27th meeting, 6-7 Dec. 1938, p. 27, letter from the secretary of the Congress outlining recommendations passed at the Third National Youth Congress and to be presented before the Rowell-Sirois Commission.

[19] Commons, *Debates*, 1938, p. 1073.

[20] *Ibid.*

[21] *Report, PNH, 1942*, p. 101.

[22] Emory, p. 70.

[23] See the foreword to Canada, House of Commons, Special Committee on Social Security, *Health Insurance. Report of the Advisory Committee on Health Insurance* (Ottawa: King's Printer, 1943), pp. xii-xvi.

[24] "I believe that crime is very often due to poor health. If people are in good health their temper is so much better . . ." Agnes Campbell MacPhail, Commons, *Debates*, 1930, p. 225.

[25] Daniel McIvor saw inability to obtain needed medical care as a factor in "driving people to certain shades of thinking." Commons, *Debates*, 1938, p. 1072.

[26] PAC, RG 29, vol. 858 (file 20-C-33, part 1) Correspondence between Executive Committee of the CMA and the Department, May 1941 to Dec. 1943.

[27] Cassidy, *Social Security and Reconstruction in Canada*, pp. 4-5. J. L. Granatstein, *The Politics of Survival, The Conservative Party of Canada, 1939-1945* (Toronto: University of Toronto Press, 1967), p. 108.

[28] Rowell-Sirois Report, Book 1, p. 216 cited in K. C. Wheare, *Federal Government* (London: Oxford University Press, 1947), pp. 158-9.

[29] Arthur Denis, Commons, *Debates*, 1931, p. 1007.

[30] J. C. Landeryou, *ibid.*, 1939 (1st session), p. 4375.

[31] See reports and correspondence in PAC, RG 29, vol. 23 (file 21-1-1).

[32] Strong, p. 228.

[33] Grauer, *Public Health*, p. 62.

[34] Commons, *Debates*, 1935, p. 1065.

[35] *Ibid.*, 1937, p. 105.

[36] Donald A. McNiven, *ibid.*, p. 2637.

[37] *Ibid.*, 1934, p. 9.

[38] *Ibid.*, p. 460.

[39] Wilbur, *The Bennett New Deal*, p. 5.

[40] F. R. Scott, "The Nineteen Thirties in the United States and Canada," in Hoar, pp. 180-1.

[41] Power, as Minister of Pensions and National Health, called a meeting of provincial ministers of health for this purpose. Power, Commons, *Debates*, 1936, pp. 2168-9.

[42] Michael S. Cross, ed., *The Decline and Fall of a Good Idea: CCF-NDP Manifestoes, 1932 to 1969* (Toronto: New Hogtown Press, 1974), p. 22.

[43] Heagerty, "The National Health Section, Department of Pensions and National Health," p. 200.

[44] Young and Routley, p. 287.

[45] *Ibid.*, p. 286.

[46] League for Social Reconstruction, *Social Planning for Canada* (Toronto: University of Toronto Press, 1975), p. 401.

[47] Peebles, pp. 472-3.

[48] Grauer, *Public Health*, pp. 4-5.

[49] Strong, p. 57.

[50] PAC, DCH Minutes, 34th meeting, June 1937, Appendix D.

[51] PAC, RG 29, vol. 23 (file 21-1-1) Interprovincial Conference, p. 6; and vol. 1062 (file 502-1-1, part 4) Recent Developments in Public Health and Medical Services in Canada, pp. 11-2.

[52] PAC, DCH Minutes, 38th meeting, 15-17 June 1939, pp. 2-3, 10 and Report of the sub-committee of the DCH.

[53] Charlotte Whitton, *The Dawn of Ampler Life* (Toronto: Macmillan, 1943), p. 4.

[54] For example, Grauer, *Public Health*, p. 2; Peebles, pp. 465-6; E. S. Moorhead, "The State and Medicine: A Comment," *CJEPS*, II (Nov. 1936), 477.

[55] For example, Agnes Campbell MacPhail, Commons, *Debates*, 1935, p. 180; James J. McCann, *ibid.*, 1937, p. 102; J. P. Howden, *ibid.*, 1939, p. 1578. This last was coupled with an oft-repeated request that the Department be done away with, to which C. G. Power, the responsible minister replied "Hear, hear." *Ibid.*, p. 1578.

[56] Marsh, *Health and Unemployment*, pp. xxiii-xxiv.

[57] See Sir William Beveridge, *Social Insurance and Allied Services* (American edition; New York: Macmillan, 1942).

[58] Strong, p. 10.

[59] Whitton, *The Dawn of Ampler Life*, pp. 25-33.

[60] PAC, RG 29, vol. 180 (file 300-1-2) 26 Dec. 1940.

[61] Cassidy, *Social Security and Reconstruction*, p. 191.

[62] See Abbott; Eveline M. Burns, *Towards Social Security, An Explanation of the Social Security Act and a Survey of the Larger Issues* (New York: McGraw-Hill, 1936); Arthur W. MacMahon, John D. Millett and Gladys Ogden, *The Administration of Federal Work Relief* (Chicago: Public Administration Service, 1941); and Arthur W. Goulding, "The National Health Survey in the United States, A Review of the Reports of the Survey of 1935-36 as issued by the United States Public Health Service," *CPHJ*, XXIX (Aug. 1938), 419-21.

[63] Cassidy, *Public Health and Welfare Organizations*, p. 11. The League of Social Reconstruction wanted to reverse the tide. One of the arguments advanced in *Social Planning for Canada* (pp. 50-1) for new Canadian initiatives in socialism was that it would be good for the tourist trade. "Hordes of eager Americans" would come north to see how it was done.

[64] Whitton, *The Dawn of Ampler Life*, p. 27.

[65] PAC, RG 29, vol. 1063 (file 502-1-1, part 6) Memorandum, Heagerty to the Minister, 7 Mar. 1938.

[66] Bell, p. 320.

[67] The expert was J. G. Fitzgerald of the University of Toronto who frequently attended the DCH meetings. Cameron R. McIntosh, Commons, *Debates*, 1931, pp. 1013-4.

[68] Cassidy, *Social Security and Reconstruction*, p. 48. "Nutrition: A National Problem," *CPHJ*, XXX (Jan. 1939), 60.

[69] The best survey of the problems can be found in Grauer, *Public Health*, pp. 17-56.

[70] Health Study Bureau, p. 1.

[71] Agnes B. Baird, "Problems in infant hygiene and what statistics reveal," *CPHJ*, XXV (April 1934), 167-70.

[72] PAC, RG 29, vol. 1061 (file 500-3-3, part 1) Post-War Public Health and Medical Services [28 Aug. 1941?], p. 2.

[73] See debate on establishment of a Ministry of Sports, Commons, *Debates*, 1937, pp. 114-25.

[74] McMillan, pp. 105-6.

[75] McGugan, p. 157.

[76] See Health Study Bureau, *passim*.

[77] See League for Social Reconstruction, pp. 391-2.

[78] G. M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932), p. 7.

[79] PAC, RG 29, vol. 1101 (file 502-7-3, part 1) Correspondence between Department and the Council regarding hospital insurance, 1935-43.

[80] "Report of the Committee on Economics of the Canadian Medical Association as presented at the Annual Meeting in Calgary June 18-22, 1934," *CMAJ*, appended to the end of vol. XXXI.

[81] Denton Massey, Commons, *Debates*, 1939 (1st session), p. 4381.

[82] Bothwell and English, p. 15.

[83] Shillington, pp. 22-3.

[84] Daniel McIvor, Commons, *Debates*, 1939 (1st session), p. 1573.

[85] McIvor, for the first time in four years, declined to introduce his plea for state medicine. *Ibid.*, 1940, p. 632.

[86] James T. Patterson, "Federalism in Crisis, A Comparative Study of Canada and the United States in the Depression of the 1930's" in Hoar, p. 7.

[87] Marsh, *Social Security for Canada*, p. 9.

[88] D. H. Williams, "Dominion Health Parade," *Canadian Affairs Pamphlets*, II (no. 5) (Ottawa: King's Printer, 15 March 1945), p. 3.

[89] Joseph Thorson, Commons, *Debates*, 1941, p. 4100.

[90] PAC, RG 29, vol. 34 (file 30-2-3) Memorandum, Heagerty to I. A. Mackenzie, 24 Feb. 1941.

[91] Ian A. Mackenzie, Commons, *Debates*, 1940, p. 594.

[92] PAC, RG 29, vol. 34 (file 30-2-3) Memorandum, Heagerty to Wodehouse, 10 Feb. 1941.

[93] Genevieve Allan, "Nutrition--Canada's Neglected Ally," *Canadian Forum*, XXII (Jan. 1941), 304.

[94] Health Study Bureau, pp. 11-3.

[95] Emory, pp. 18-9.

[96] Dolman, p. 398.

[97] G. H. Castleden, Commons, *Debates*, 1941, p. 1605.

[98] PAC, RG 29, vol. 34 (file 30-2-3) Memorandum, Heagerty to Power, 5 July 1940.

[99] Mackenzie, Commons, *Debates*, 1940, p. 630.

[100] Howard C. Green, *ibid.*, p. 595.

[101] Green, *ibid.*, p. 604.

[102] *Ibid.*, p. 600.

[103] Victor Quelch, *ibid.*, 1942, p. 578.

[104] James J. McCann, *ibid.*, 1940, p. 602.

[105] PAC, RG 29, vol. 34 (file 30-2-3) Correspondence regarding medical rejections, Oct. 1940 - Feb. 1941.

[106] *Ibid.*, Memorandum, Heagerty to Wodehouse, 10 Feb. 1941.

[107] J. F. Pouliot, Commons, *Debates*, 1940, p. 639.

[108] PAC, RG 29, vol. 181 (file 302-1-3).

[109] See the sections on civil defence in *Report, PNH*, 1940, pp. 151-3; *1941*, pp. 163-5; *1942*, pp. 155-7; *1943*, pp. 59-64; *1944*, pp. 70-5.

[110] PAC, RG 29, vol. 34 (file 30-2-4).

[111] See Report of the *National Health Survey* put out by the Board for details.

[112] PAC, RG 29, vol. 101 (file 156-2-11, part 1).

[113] Health Study Bureau, pp. 18-9.

[114] PAC, RG 29, vol. 611 (file 30-1-4) Account of War Activities . . ., 91 pages.

[115] PAC, DCH Minutes, 39th meeting, 11-12 Oct. 1939, resolutions.

[116] PAC, RG 29, vol. 109 (file 180-26-1) Memorandum regarding Nutrition Division, unsigned, undated.

[117] See *Report, PNH, 1940*, pp. 153-5; *1941*, p. 165; *1942*, pp. 153-4; *1943*, p. 57.

[118] Power, Commons, *Debates*, 1939 (1st session), p. 4374.

[119] For example, cod liver oil. PAC, RG 29, vol. 239 (file 335-5-3).

[120] *Report, PNH, 1943*, p. 55. For an example of a dietary survey see Percy Moore, H. D. Kruse and F. F. Tisdall, "Nutrition in the North,"

Beaver, Outfit 273 (Mar. 1943), 21-3.

[121] For example, life insurance companies. PAC, RG 29, vol. 110 (file 180-26-22).

[122] PAC, RG 29, vol. 44 (file 40-1-7) Brooke Claxton, Minutes of the Voluntary Parliamentary Health Committee, 20 Sept. 1945, p. 6.

[123] *Ibid.*, vol. 109 (file 180-26-1) Memorandum, L. B. Pett, Director of Nutrition Services to Heagerty, 21 July 1942.

[124] L. B. Pett, "Nutritional Planning," *CPHJ*, XXXIV (Feb. 1943), 58.

[125] Allan, p. 304.

[126] Defries, *The Development of Public Health in Canada*, p. 172.

[127] PAC, RG 29, vol. 23 (file 21-1-1) Activities of Dominion and Provincial Departments of Health in Respect to Overlapping, p. 3. See *ibid.*, vols. 506 to 509, for representative Division studies.

[128] *Report, PNH, 1939*, pp. 147-8.

[129] PAC, DCH Minutes, 39th meeting, 11-12 Oct. 1939, Appendix D.

[130] *Report, PNH, 1940*, pp. 145-6; *1941*, pp. 157-8.

[131] PAC, RG 29, vol. 506 (file 453-1-3) Memorandum, Kingsley Kay, Chief of Division to Heagerty, 26 July 1941; vol. 614 (file 453-3-1).

[132] *Canada in World War II. Post-War Possibilities* (Montreal: William S. Boas and Co., 1945), p. 78.

[133] *Report, PNH, 1944*, pp. 58-9.

[134] PAC, RG 29, vol. 615 (file 454-10-1, part 1).

[135] *Ibid.*, vol. 506 (file 453-1-3) Memorandum, C. F. Blackler, Acting Chief of Industrial Hygiene Division to Heagerty, 18 Jan. 1944.

[136] J. F. Pouliot, Commons, *Debates*, 1940, p. 646.

[137] PAC, RG 29, vol. 19 (file 10-3-1) Memorandum, Sharman to the Minister, 30 Oct. 1944.

[138] *Ibid.*, vol. 539 (file 320-3-4, parts 1-10); vol. 543 (file 320-4-9, parts 1-3) and vol. 544 (files 320-4-9, parts 4-6).

[139] PAC, RG 29, vol. 611 (file 30-1-4) Account of War Activities . . ., pp. 26-34. Selected files in *ibid.*, vols. 567, 568, 570, 571, 573, 574, 576 and 577 show how tight the control was.

[140] *Report, PNH, 1945*, pp. 14-26.

[141] Pouliot, Commons, *Debates*, 1940, p. 647.

[142] *Report, PNH, 1942*, p. 105.

[143] *Canada in World War II*, p. 79.

[144] *Report, PNH, 1940*, p. 101.

[145] *Ibid., 1941*, pp. 106-7.

[146] PAC, RG 29, vol. 250 (file 339-4-7, parts 1 and 2); vol. 251 (file 339-4-7, parts 3-5); vol. 252 (file 339-4-8, part 1).

[147] *Report, PNH, 1941*, p. 107.

[148] PAC, RG 29, vol. 242 (file 336-2-14, parts 1-3).

[149] *Ibid.*, vol. 613 (file 339-5-6).

[150] *Report, PNH, 1943*, p. 37.

[151] *Ibid., 1944*, pp. 39-40.

[152] Canada, *Report of the Department of National Health and Welfare* [hereinafter *Report, NHW*], *1945*, p. 27.

[153] *Report, PNH, 1941*, p. 147.

[154] *Canada in World War II*, p. 79. *Report, PNH, 1943*, p. 43.

[155] *Report, PNH, 1944*, p. 45.

[156] *Report, NHW, 1945*, pp. 44-5.

[157] *Report, PNH, 1940*, p. 126.

[158] *Ibid., 1942*, pp. 131-2. For Alaska Highway work camps see PAC, RG 29, vol. 270 (file 369-1-9).

[159] *Report, PNH, 1944*, pp. 40-1.

[160] *Ibid.*, 1943, p. 39. See selected files in PAC, RG 29, vols. 262-269.

[161] *Canada in World War II*, p. 79.

[162] *Report, NHW, 1945*, p. 31.

[163] See, for example, *Report, PNH, 1943*, pp. 42-3.

[164] PAC, RG 29, vol. 287 (file 402-3-2) Letter from U. Coch [?illegible], federal health officer at Halifax to C. P. Brown, Chief of Immigration Medical Services, 13 Oct. 1941.

[165] *Report, PNH, 1941*, pp. 138-41.

[166] PAC, RG 29, vol. 611 (file 30-1-4) Account of the War Activities . . ., p. 78.

[167] *Report, PNH, 1943*, p. 42.

[168] *Canada in World War II*, p. 79.

[169] *Report, PNH, 1939*, pp. 148-52.

[170] PAC, RG 29, vol. 611 (file 30-1-4) Account of the War Activities . . ., p. 21.

[171] *Report, PNH, 1941*, p. 159; *1942*, p. 148; *1944*, p. 59.

[172] *Ibid., 1944*, pp. 59-60.

[173] *Report, NHW, 1945*, p. 54.

[174] PAC, RG 29, vol. 611 (file 30-1-4) Account of the War Activities . . ., pp. 19-23.

[175] *Report, PNH, 1942*, p. 151.

[176] *Ibid.* For examples of radio scripts, see PAC, RG 29, vol. 120 (file 190-1-1, part 1).

[177] PAC, RG 29, vol. 22 (file 20-H-3).

[178] PAC, RG 29, vol. 116 (file 186-1-2) Memorandum prepared by J. C. Young, Acting Director of Publicity and Health Education, 2 Oct. 1942.

[179] *Report, PNH, 1939*, p. 140.

[180] R. B. Hanson, Commons, *Debates*, 1940, p. 1620.

[181] Mackenzie, *ibid.*, p. 1621.

[182] See *Report, PNH, 1941*, pp. 154-7; *1942*, pp. 144-7; *1944*, pp. 51-8.

[183] See *ibid., 1938*, pp. 142-3.

[184] *Ibid., 1940*, pp. 148-50.

[185] *Ibid., 1932*, pp. 127-9.

[186] *Ibid., 1931*, p. 130.

[187] Edward J. Garland, Commons, *Debates*, 1932-33, p. 3115. PAC, DCH Minutes, 33rd meeting, 2-3 Nov. 1936, pp. 2-5 and 35th meeting, 15-16 Oct., 1937, p. 16. Bates, "Venereal Disease Control in Canada," pp. 60-6 and Bates, "The Venereal Disease Problem in Canada," pp. 485-92.

[188] The amount of material on venereal disease in the papers of the Department of National Health and Welfare is extensive. For sampling, see vols. 99, 109, 116, 122, 205-220, 499, 501 and 502.

[189] Power, Commons, *Debates*, 1938, pp. 3308-9.

[190] Cassidy, *Social Security and Reconstruction*, p. 27.

[191] See Alberta, Department of Public Health, *The Proceedings of the Second Western Canada Conference on Venereal Disease, Edmonton, 8-9 October 1942* (Edmonton: King's Printer, 1942[?]). D. H. Williams, "Canada's First National Venereal Disease Control Conference," *CMAJ*, L (Feb. 1944), 157-8. For information on one aspect of military anti-VD work see Ruth Roach Pierson, "The Double Bind of the Double Standard; V.D. Control and the Canadian Women's Army Corps in WWII," a paper given before the annual meeting of the Canadian Historical Association, Saskatoon, June 1979.

[192] *Report, PNH, 1944*, p. 60.

[193] *Report, NHW, 1945*, pp. 54-62.

[194] PAC, RG 29, vol. 1233 (file 311-V2-1, part 1) Major Georges LeClerc, Acting Chief of VD Control to Dr. C.F.W. Hames, Deputy Minister of Public Health, Saskatchewan, 30 Aug. 1945.

[195] Cassidy, *Social Security and Reconstruction*, p. 66.

[196] See debate in Senate, *Debates*, 1943-44, pp. 371-3.

[197] Mackenzie, Commons, *Debates*, 1943, p. 5038; 1944, p. 3831.

[198] *Report, NHW, 1945*, pp. 64-8.

[199] PAC, RG 29, vol. 20 (file 10-3-3) Memorandum, Ian Eisenhardt, National Director of Physical Fitness to Olive J. Waters, Administrative Assistant of Department, 8 Feb. 1946.

[200] T. C. Douglas, Commons, *Debates*, 1940, p. 1625. Cora T. Casselman, *ibid.*, 1942, p. 430. Joseph J. McCann, *ibid.*, pp. 5158-9.

[201] According to the Wartime Information Board. See J. L. Granatstein, *Canada's War: The Politics of the Mackenzie King Government, 1939-1945* (Toronto: Oxford University Press, 1975), p. 251.

[202] For examples see Cassidy, *Social Security and Reconstruction*, p. 189; James J. McCann, "Canada's War Effort for the Health of the People," *CPHJ*, XXXII (Dec. 1941), 593; Charlotte Whitton, "The Reconstruction of Social Services" in Alexander Brady and F. R. Scott, eds., *Canada after the War: Studies in Political, Social and Economic Policies for post-war Canada* (Toronto: Macmillan, 1944), pp. 88-9.

[203] Granatstein, *Canada's War, passim* and *The Politics of Survival, passim.*

[204] The references to revolution started in the Depression and continued into and after the war. For example, see Allan, p. 305; Cassidy, *Unemployment and Relief*, pp. 254-7; Granatstein, *Canada's War*, p. 397; Grauer, *Public Health*, p. 39; Raphael Tuck, "Social Security: An Administrative Solution to the Dominion-Provincial Problem," *CJEPS*, XIII (May 1947), 256; Young and Routley, p. 290.

[205] H. E. Spencer, Commons, *Debates*, 1934, p. 507. Woodsworth, *ibid.*, p. 148.

[206] For an example of Department policy on post-war reform see Memorandum on the function of research and information in relation to government planning and social legislation, 5 pages, by Jeff Hurley, Director of Information Services, April 1945. PAC, RG 29, vol. 1063 (file 502-1-1, part 10).

[207] H. E. Sigerist, "Medical Care for all the People," *CPHJ*, XXXV (July 1944), 253. Emphasis his.

[208] PAC, DCH Minutes, 41st meeting, 12-14 June 1941, pp. 12-21.

[209] Peebles, pp. 466-7. For a comparative study, see Cudmore.

[210] See the short summary of relevant information in Blyth, pp. 109-11.

[211] See Paul H. Douglas, *Social Security in the United States. An Analysis and Appraisal of the Federal Social Security Act* (New York: Whittlesey House, 1936), p. 68. For later, longer analyses see Maurice B. Hamovitch, "History of the Movement for Compulsory Health Insurance in the United States," *Social Service Review*, XXVII (Sept. 1953), 281-99; and Daniel S. Hirschfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943* (Cambridge: Harvard University Press, 1970).

[212] For example, the Montreal Group for the Security of the People's Health, headed by Norman Bethune. PAC, RG 29, vol. 1062 (file 502-1-1, part 4) Medical Care for the People of Montreal and the Province of Quebec.

[213] Peebles, p. 472.

[214] J. L. Granatstein, "Mackenzie King and the Turn to Social Welfare, 1943-45," *Quarterly of Canadian Studies*, II (Spring 1972), 14.

[215] F. R. Scott, "The Constitution and the Post-War World" in Brady and Scott, p. 61.

[216] Stuart K. Jaffary, "Social Security: The Beveridge and Marsh Reports," *CJEPS*, IX (Nov. 1943), 571.

[217] "John Joseph Heagerty," obituary, *CPHJ*, XXXVII (Feb. 1946), 75.

[218] PAC, DCH Minutes, 24th meeting, 28-31 May 1932, p. 1.

[219] Wodehouse, pp. 370 and 376. PAC, DCH Minutes, 27th meeting, 16-18 Oct. 1933, p. 1.

[220] See RG 29 files and Dominion Council of Health Minutes for negative evidence. For supporting opinion see Robert S. Bothwell, "The Health of the Common People" in *Mackenzie King: Widening the Debate*, edited by John English and J. O. Stubbs (Toronto: Macmillan, 1977), p. 194.

[221] See clippings in Brock Chisholm papers, MG 30, B56, vols. 1 and 9.

[222] James A. Calder, 1921 (he was also Minister of Immigration and Colonization at the same time); Henri S. Béland, 1922-25; John C. Elliott and R. J. Manion, both in 1926; and James H. King, 1926-30.

[223] Taylor, "The Role of the Medical Profession in the formulation and execution of public policy," p. 116.

[224] C. G. Power, "Progress in Public Health in Canada," *CPHJ*, XXVII (Aug. 1936), 380.

[225] For example see Commons, *Debates*, 1936, pp. 2165-6.

[226] Granatstein, *Canada's War*, pp. 25-6.

[227] PAC, DCH Minutes, 22nd meeting, 23-25 June 1931, pp. 16-35.

[228] Editorial, *CPHJ*, XXXIV (Mar. 1943), 143.

[229] James J. McCann, "Health Insurance from the Public Health Standpoint," *CPHJ*, XXXV (Feb. 1944), 62.

[230] PAC, DCH Minutes, 42nd meeting, 26-27 Mar. 1942, Appendix B.

[231] Cassidy, *Public Health and Welfare Organization*, p. 1.

[232] See Special Committee on Social Security, *Health Insurance. Report of the Advisory Committee on Health Insurance*. Partly to demonstrate its support for the study, the *CPHJ* reprinted several of these submissions during 1943. For a short summary of the proposals, presented before the conference of Dominion and Provincial Ministers and Deputy Ministers of Health in Ottawa, 10-12 May 1944, see Ian A. Mackenzie, "Health Insurance," *CPHJ*, XXXV (June 1944), 213-33.

[233] Canada, Parliament, House of Commons Special Committee on Social Security, *Minutes and Proceedings* (Ottawa: King's Printer, 1943), pp. 58-9.

[234] McCann, "Health Insurance from the Public Health Standpoint," p. 59. D. S. Lewis and F. W. Jackson, "Integration of Preventive and

Curative Medicine in National Health Insurance," *CPHJ*, XXXV (Mar. 1944), 99-108.

[235] See Canada, House of Commons, Special Committee on Social Security, *Health Insurance. Report of the Advisory Committee on Health Insurance.* The files on health insurance in the papers of the Department of National Health and Welfare housed in the Public Archives of Canada, are voluminous. See especially vols. 1058 to 1144. Two detailed studies on the rise and fall of the health insurance proposals have quite recently entered the literature. One is Bothwell's chapter in *Mackenzie King: Widening the Debate* edited by English and Stubbs. He treats mostly the political aspects of the problem. The longer and more detailed work is the first chapter, "The 1945 Health Insurance Proposals: Policymaking for Post-War Canada," in Malcolm G. Taylor, *Health Insurance and Canadian Public Policy. The Seven Decisions that Created the Canadian Health Insurance System* (Montreal: McGill-Queen's Press, 1978), pp. 1-68. See also Irving J. Goffman, "The Political History of National Hospital Insurance in Canada," *Journal of Commonwealth Political Studies*, III (July 1965), 136-40.

[236] Cassidy, Social Security and Reconstruction, p. 159. Grauer, *Public Health*, p. 74.

[237] L. Richter, "The Effect of health insurance on the demand for health services," *CJEPS*, X (May 1944), 179-205.

[238] League for Social Reconstruction, pp. 397-8: Moorhead, pp. 477-80. William R. Davies. Senate, *Debates*, 1943-44, p. 17.

[239] Canada, Department of National Health and Welfare, *Social Security in Canada* (Ottawa: Information Canada, 1974), p. 3.

[240] Health Study Bureau, pp. 11-22.

[241] A. D. Watson, Chief Actuary, Department of Insurance. PAC, DCH Minutes, 41st meeting, 12-14 June 1941, pp. 20-1.

[242] H. E. MacDermot, "Health Insurance in Canada," *Queen's Quarterly*, LI (Aug. 1944), 316.

[243] Matters, p. 28.

[244] Daniel McIvor, Commons, *Debates*, 1938, p. 1070.

[245] Williams, "Dominion Health Parade," p. 17.

[246] MacDermot, "Health Insurance in Canada," p. 319.

[247] Malcolm G. Taylor, *The Administration of Health Insurance in Canada* (Toronto: Oxford University Press, 1956), pp. 212-3.

[248] Taylor, "The Role of the medical profession in the formulation and execution of public policy," p. 114.

[249] PAC, RG 29, vol. 1062 (file 502-1-1, part 1) Correspondence between the CMA and the Department, Dec. 1929 to March 1930.

[250] T. J. O'Neill, Commons, *Debates*, 1939 (1st session), pp. 1583-4.

[251] Wodehouse, p. 369.

[252] PAC, RG 29, vol. 858 (file 20-C-33, part 1) T. C. Routley to Wodehouse, 13 Feb. 1940.

[253] *Ibid.*, Wodehouse to T. H. Leggett, 15 June 1940.

[254] PAC, RG 29, vol. 613 (file 339-5-2) Heagerty to Wodehouse, 28 Nov. 1939.

[255] *Ibid.*, vol. 1107 (file 504-1-2, part 1) Correspondence between College and Department, March to December 1942.

[256] For most of the correspondence between the Department and the CMA on health insurance, see PAC, RG 29, vol. 1111 (file 304-2-4, part 1).

[257] *Ibid.*, vol. 858 (file 20-C-33, part 1) Wodehouse to T. C. Routley, 9 Sept. 1941.

[258] *CMAJ*, XLVI (1942), 389. Quoted in H. E. MacDermot, "A Short History of Health Insurance in Canada," *CMAJ*, L (May 1944), 452.

[259] PAC, RG 29, vol. 1111 (file 304-2-4, part 1) Memorandum, Heagerty to Minister, 9 April 1942. He did so.

[260] Bothwell and English, p. 16.

[261] Daniel McIvor, Commons, *Debates*, 1943, p. 153.

[262] Taylor, "The Role of the Medical Profession," p. 119.

[263] Gordon S. Fahrni, *Prairie Surgeon* (Winnipeg: Queenston House Pub., 1976), p. 71.

[264] For example, see Emile Bouvier, "L'Avant-projet de loi d'assurance-santé," *Rélations*, IV (Nov. 1944), 286-9.

[265] See Whitton, *The Dawn of Ampler Life*, a critique of the Heagerty, Marsh and Beveridge reports. Although the book stresses that it is not the product of any political party, its connections with the Progressive Conservatives are obvious. Granatstein says in *Canada's War* (pp. 261-2) that "the net effect of the Whitton book was to suggest that the Progressive Conservative Party was still more conservative than progressive."

[266] PAC, RG 29, vol. 1063 (file 502-1-1, part 6) Letter, Heagerty to Max J. Webster of the Imperial Bank of Canada, Essex, Ontario, 8 Mar. 1940.

[267] "The Present Status of National Health Insurance," editorial, *CPHJ*, XXXV (June 1944), 249.

[268] Canada, Federal-Provincial Conference, Conference #12, Ottawa, Jan. 1933. Quoted from a memorandum by Heagerty regarding Social Insurance which in turn quotes William S. Edwards, Deputy Minister of Justice, 10 May 1928.

[269] PAC, RG 29, vol. 1063 (file 502-1-1, part 7) Quoted in memorandum from Heagerty, Ross Millar and F. S. Burke to Wodehouse, 7 Jan. 1941, p. 3.

[270] G. H. Castleden, Commons, *Debates*, 1940, p. 641.

[271] Cassidy, *Social Security and Reconstruction*, p. 157.

[272] Bothwell and English, p. 17.

[273] Cassidy, *Social Security and Reconstruction*, p. 26.

[274] League for Social Reconstruction, p. 149.

[275] Aucoin, pp. 56-7.

[276] See Luella Gettys, *The Administration of Canadian Conditional Grants* (Chicago: Public Administration Service, 1938) and J. A. Maxwell, *Federal Subsidies to the Provincial Governments in Canada* (Cambridge, Mass.: Harvard University Press, 1937).

[277] For example, J. H. Blackmore, Commons, *Debates*, 1944, p. 4258.

[278] Grauer, *Public Health*, pp. 62-3.

[279] PAC, RG 29, vol. 1064 (file 502-1-3) Memorandum, Wodehouse to Heagerty, 22 Nov. 1941.

[280] *Ibid.* Letter, F. P. Varcoe of Department of Justice to Wodehouse, 26 Nov. 1941. The health insurance files contain many references to the constitutional problem. Another is vol. 1063 (file 502-1-1, part 6) Memorandum, Wodehouse to Minister, 10 May 1940.

[281] *Ibid.*, vol. 1061 (file 500-3-3, part 1) Memorandum, J. L. Ilsley of the Department of Finance to Mackenzie, 28 Nov. 1941.

[282] Quoted in J. W. Pickersgill, *The Mackenzie King Record, Volume I, 1939-1944* (Toronto: University of Toronto Press, 1960), p. 636.

[283] For opinion on how the BNA Act can and cannot be bent, see the relevant sections in Birch and Wheare. J. A. Corry, *The Growth of Government Activities since Confederation* (Ottawa: Royal Commission on Dominion-Provincial Relations, 1939) argued that Confederation had been engineered at an anomalously high point in belief in *laissez-faire* and that government intervention was the norm now being returned to.

[284] Marsh, *Social Security for Canada*, p. 28; Grauer, *Public Health*, p. 3.

[285] Adélard Groulx, "A National Health Program," *CPHJ*, XXIV (Jan. 1943), 13.

[286] A. E. Grauer, *Public Assistance and Social Insurance* (Ottawa: Royal Commission on Dominion-Provincial Relations, 1940), p. 55.

[287] PAC, DCH Minutes, 26th meeting, 13-15 June 1933, p. 25.

[288] See numerous references in Commons, *Debates*, 1938, pp. 1072-1108.

[289] McCann, "Health Insurance from the Public Health Standpoint," p. 60.

[290] Williams, "Dominion Health Parade," pp. 9-10.

[291] PAC, RG 29, vol. 1063 (file 502-1-1, part 10) Letter, Heagerty to Gordon Bates of the Health League of Canada, 2 Feb. 1944. George F. Davidson, "Proposals for Health Insurance" in *Canada and the World Tomorrow*, edited by Violet Anderson (Toronto: Ryerson Press, 1944), p. 127.

[292] See George Newman, *Building a Nation's Health* (London: Macmillan, 1939).

[293] Weir, p. 47.

[294] Graham Spry, "The C.C.F. Party in its Formative Years" in Hoar, p. 230.

[295] See M. J. Coldwell, *Left Turn, Canada* (London: Victor Gallancz, 1945).

[296] PAC, RG 29, vol. 19 (file 10-3-1) Aide Memoire for Brock Chisholm, 13 Dec. 1944. "Official Dominion-Provincial conference on Health Insurance postponed due to war, election and political tension. Nevertheless the need for Health Insurance advance obviously needs stimulation otherwise it will be revived by a CCF measure to introduce a straight State Medical Service."

[297] Granatstein, *The Politics of Survival*, p. 189.

[298] Blishen, pp. 140-9; Goffman, p. 140.

[299] D. W. Gullett, *A History of Dentistry in Canada* (Toronto: University of Toronto Press for Canadian Dental Association, 1971), pp. 207-12.

[300] "John Joseph Heagerty," p. 75.

[301] See Appendix B for relevant excerpts from the Act to establish

the Department of National Health and Welfare.

[302] Herbert A. Bruce, Commons, *Debates*, 1940, pp. 3823-4. Mackenzie King, *ibid.*, p. 4256. "Canada Needs a National Department of Health," pp. 203-4. The matter had been discussed before the Rowell-Sirois Commission. See Grauer, *Public Health*, p. 5. and Young and Routley, p. 289.

[303] See the activities of the new department as outlined by Brooke Claxton, Commons, *Debates*, 1945, pp. 2830-3.

[304] Health jurisdiction, both federal and provincial, was still confused at the onset of World War II. See Ernest H. Blois, "Social Services and Public Health," *CPHJ*, XXX (Feb. 1939), 105-8. The transferral of Indian Health Services from the Department of Mines and Resources had particularly been called for for quite some time. See PAC, DCH Minutes, 30th meeting, 6-8 June 1935, pp. 9-13; Maundrell, p. 79 and Graham-Cumming, pp. 127-8. Unfortunately, the transfer then led to conflict with the new Department of Indian Affairs.

[305] J. H. King, Senate, *Debates*, 1944-45, pp. 328-9.

[306] *Report, NHW, 1946*, pp. 7-8.

[307] Name withheld. Personal interview, 8 June 1978.

> The state of complete physical,
> mental and social well-being and not
> merely the absence of disease . . .
> --World Health Organization's
> definition of good health, quoted
> in C. Howard Shillington, *The Road
> to Medicare in Canada*, p. 1.

CONCLUSION

The Canadian federal Department of Health was established at a time when it was accepted that poor health was a problem largely amenable to strictly scientific solutions. Application of preventive solutions lay with public health officials. They were to fulfill their duties by two means. One was to apply quarantine and quarantine-type measures to keep health hazards away from the general populace as much as possible. The second way was to provide information that would teach people to look after themselves. But the major part of scientific application lay with the medical profession. Doctors were to handle the curative solutions--to regenerate the individual whose health, through self-neglect or ill luck, had broken down. Already by 1919, this system was proving to be obsolete. The major epidemic diseases were on the run: the influenza epidemic of 1918-19 had been a last gasp, not a portent. Canada's elaborate quarantine network would never be seriously taxed. Neither would the amount of time and effort put into health propaganda pay the dividends expected. The propaganda usually urged two courses of action: to improve one's standard of living or to consult a doctor. Often Canadians could afford neither. Doctors also failed to deliver their side of the bargain, particularly when it came to the four health problems about which Canada was most concerned--venereal disease, tuberculosis, infant and maternal mortality and mental illness. Some scientific knowledge could be applied by the individual doctor to the individual patient but such treatment would not make a dent in these nation-wide problems as a whole. When the obsolescent approach supervised by the Department of Health had failed by the late 1920s to yield the desired results, the Department was tied to Pensions, both concerns having lost their urgency with the passing from memory of the reform euphoria of the Great War.

Responsibility for health care fell, by default, to the dispensers of curative solutions--not only the doctors but other health professionals and the hospitals. It was the proven bankruptcy of this system, in turn, especially during the Depression, that led to a new surge of reform. It was the return of warfare that once again allowed such reform concerns to be seriously considered: national strength of every kind was again needed to ensure victory. The reform dreams accompanying World War II were different from those accompanying World War I. The intervening Depression had taught Canadians, as well as others, that even respectable middle-class persons eager to make their own way in the world could not always do so. Under certain circumstances, it seemed, almost anyone might need help. Social insurance in its various forms would remove any stigma that might be attached to aid sought in time of need. Individual Canadians would pay into a fund. Should they have need, they could then draw on this fund. This was a matter of right, not of charity.

At one point it seemed that provision of medical care would be an integral part of post-war social insurance schemes. After all, inability to pay for medical attention had certainly been a common misfortune in the Depression. But health insurance failed to gain sufficient support for several reasons, not all of which had to do with the vagaries of the BNA Act or fidgety negotiations with the Canadian medical profession. Probably the biggest blow to proposed health reform was the shaking of the belief that illness was the major cause of destitution. It was true that ill health might render a person incapable of holding a job but the unemployment of the Depression was due to another reason--simple lack of jobs. Whereas after the Great War and for at least a century before that, reformers had felt that health reforms would go a long way to solving various other social problems, the reverse now seemed to hold. It was not enough that Canadians be in good physical shape and that certain threats to communal health be removed. Such undertakings could not guarantee either individual or national prosperity. However, it did seem that prosperity went a long way to guaranteeing good health. Specific health reforms would not receive the priority that general social reforms would.

Still, it must be remembered that medical care insurance, the major health reform suggested, was not abandoned precipitately. It was simply put off, sent back to the Department's Directorate of Health Insurance Studies for further consideration. Had conditions been different, it might have been resurrected. But certain changes in medical technology and in the Canadian economy and society following World War II brought amelioration of some previously unsatisfactory conditions. By the end of the war, the nation's four great specific health problems were beginning to fall to scientific advancement:

the venereal diseases to penicillin; tuberculosis to the antimicrobial drugs; infant and maternal mortality again to penicillin and to mechanical devices such as incubators for premature babies and surgical techniques like the caesarean section; and certain types of mental illness to chemical preparations such as barbiturates, the shortcomings of which were not to become apparent for some years. What was left were the health problems connected with lifestyle--at that time, the problems of poverty. And poverty did not prove as big a problem after the war as had been expected. Canadians in general could afford to pay their doctors and buy other necessary services, medicines and devices. They could also, by comparison, afford to live well. Neither was isolation from medical facilities and personnel as much a problem as before. The federal and provincial governments managed to negotiate the conditional grants section of the wartime health proposals by 1948, providing funds for the building of more hospitals and the training of more health professionals. Increased urbanization and improved transportation also brought people closer to the facilities they needed. Social welfare provisions would be relied upon to take care of any Canadians failing, for shorter or longer periods of time, to claim their share of the new prosperity.

Prosperity also brought two products that would eventually help lead in turn to acceptance of health insurance by the late 1960s. One was increased scientific research which produced straightforward, although not always successful, treatment for ailments that were formerly accepted as facts of life. Cancer, heart disease, physical disfiguration, some types of mental retardation, birth defects and other physical problems all fell before technological advance. The other product of prosperity was a rise in expectations: Canadians felt they had a right to the fruits of science. Health insurance was a way of bringing consumers together with the producers of these often expensive techniques. But the introduction of health insurance would not lead to a reinvigoration of the federal health division. Although backed by the Dominion, financially and in other ways, health insurance was to be administered by the provinces. In reality, this is in keeping with health jurisdiction as understood at the end of the Great War. The provinces were expected from the first to take charge of the treatment aspect. Health insurance meant that they now handled provision of personal means as well as of public facilities. The Dominion was still seen as dealing mostly in public health from a preventive point of view and for all its many good qualities, health insurance as currently constructed cannot be seen as a component part of preventive medicine. If anything, it deflects the necessity for innovation of new types and application of old types of prevention by allowing recourse to manipulative methods of cure. But can meaningful measures of prevention be introduced? It is entirely possible that the major threats to Canadian health are as much outside the realm of specific health reform today as they were in the era between the two world wars.

Since the subjugation of the communicable diseases, the problems of health have become largely the problems of lifestyle. Whereas before these were the problems of poverty, they are now those of affluence. Canadians live materially richer lives than before and they live longer. Both factors mean that a larger segment of the population is going to suffer from degenerative diseases. Industry has exposed everyone to new substances the health hazards of which are often only guessed at or ignored. Medical technology has made it possible for certain people to live who before would have died--but only at the expense of frequently long-term constant treatment or care. The medical care system is expensive, perhaps too expensive to carry on in its current form of organization. We have come to another period when poor health is very much being treated as a problem largely amenable to strictly scientific solutions. The scientific solutions have widened and improved but they still represent stop-gap answers to long-term problems. At the end of the Great War, Canadian reformers wanted reforms that would allow for the improvement of the physical well-being of all Canadians. A lasting solution has not yet been found.

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APPENDIX A

9-10 GEORGE V.

CHAP. 24.

An Act respecting the Department of Health.

[Assented to 6th June, 1919.]

WHEREAS it is expedient, for the preservation of the health and the promotion of the social welfare of the people of Canada, that a Department of Health be established in the Dominion: Therefore His Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:-

1. This Act may be cited as *The Department of Health Act.*

2. There shall be a Department of the Government of Canada which shall be called "The Department of Health," over which a Minister of the Crown to be named by the Governor in Council shall preside.

3. (1) The Governor in Council may appoint an officer, who shall be called "the Deputy Minister of Health," who shall be the deputy head of the Department and who shall hold office during pleasure.

(2) Such other officers, clerks and employees as are necessary for the proper conduct of the business of the Department may be appointed in accordance with the provisions of *The Civil Service Act, 1918*, and of any Acts in amendment thereof, all of whom shall hold office during pleasure.

(3) The Governor in Council may, subject to the provisions of *The Civil Service Act, 1918*, or any amendment thereto, transfer to the Department of Health any officer, clerk or employee now in the employ of His Majesty or of either or both Houses of Parliament, and subsection two of section seventeen of the said Act shall not apply to such transfers, and the money voted by Parliament for the financial year ending the thirty-first day of March, one thousand nine hundred and twenty, applicable to the payment of the salary or the increase of salary of any such officer, clerk or employee so transferred shall be available for the payment of his salary or increase of salary or the salary of any person appointed in his place in case of his death, retirement or dismissal while serving in the Department of Health, in the same manner and to the same extent as if such officer, clerk or employee had not been so transferred.

4. The duties and powers of the Minister administering the Department of Health shall extend to and include all matters and questions relating to the promotion or preservation of the health of the people of Canada over which the Parliament of Canada has jurisdiction; and, without restricting the generality of the foregoing, particularly the following matters and subjects:-

(a) Co-operation with the provincial, territorial, and other health authorities with a view to the co-ordination of the efforts proposed or made for preserving and improving the public health, the conservation of child life and the promotion of child welfare;

(b) The establishment and maintenance of a national laboratory for public health and research work;

(c) The inspection and medical care of immigrants and seamen, and the administration of Marine Hospitals;

(d) The supervision, as regards the public health, of railways, boats, ships and all methods of transportation;

(e) The supervision of Federal public buildings and offices with a view to conserving and promoting the health of the Civil Servants and other Government employees therein;

(f) The enforcement of any rules or regulations made by the International Joint Commission, promulgated pursuant to the treaty between the United States of America and His Majesty relating to boundary waters and questions arising between the United States of America and Canada, so far as the same relate to public health;

(g) The administration of the statutes mentioned in the Schedule of this Act, and of Acts amending the same, and also of all orders and regulations passed or made under any of the said Acts; and all the duties and powers of any Minister of the Crown under either of the said Acts or any of the said orders or regulations, are hereby transferred to and conferred upon the Minister of Health;

(h) Subject to the provisions of *The Statistics Act*, the collection, publication and distribution of information relating to the public health, improved sanitation and the social and industrial conditions affecting the health and lives of the people;

(i) Such other matters relating to health as may be referred to the Department by the Governor in Council.

5. The Governor in Council shall have power to make such regulations as may be necessary to give effect to and carry out the objects of this Act, and to impose penalties for any violation of such regulations.

6. There shall be a Dominion Council of Health consisting of the Deputy Minister of Health, who shall be chairman, the chief executive officer of the Provincial Department or Board of Health of each Province, and such other persons, not to exceed five in number, as may be appointed by the Governor in Council, who shall hold office for three years. The Dominion Council shall meet at such times and places as the Minister may direct, and shall be charged with such duties and powers in respect to this Act as the Governor in Council may prescribe.

7. Nothing in this Act or in any regulation made thereunder shall authorize the Minister or any officer of the Department to exercise any jurisdiction or control over any Provincial or Municipal Board of Health or other health authority operating under the laws of any province.

8. The Minister shall annually lay before Parliament within fifteen days after the meeting thereof, a report and statement of the transactions and affairs of the Department during the year then next preceding.

APPENDIX B

8 GEORGE VI.

CHAP. 22.

An Act to establish a Department of National Health and Welfare.

[Assented to 24th July, 1944.]

5. The duties, powers and functions of the Minister shall extend to and include all matters relating to the promotion or preservation of the health, social security and social welfare of the people of Canada over which the Parliament of Canada has jurisdiction, and, without restricting the generality of the foregoing, particularly the following matters:-

(a) the administration of such acts of the Parliament of Canada and of orders or regulations of the Government of Canada as are not by law assigned to any other department of the Government of Canada or any minister thereof relating in any way to the health, social security and welfare of the people of Canada;

(b) investigation and research into public health and welfare;

(c) the inspection and medical care of immigrants and seamen, and the administration of marine hospitals, and such other hospitals of the Government of Canada as may be committed to its administration by order of the Governor in Council;

(d) the supervision, as regards the public health, of railways, boats, ships and all other methods of transportation;

(e) the promotion and conservation of the health of the civil servants and other Government employees;

(f) the enforcement of any rules or regulations made by the International Joint Commission, promulgated pursuant to the treaty between the United States of America and His Majesty relating to boundary waters and questions arising between the United States of America and Canada, so far as the same relate to public health;

(g) the administration of the *Food and Drugs Act*, *The Opium and Narcotic Drug Act*, the *Quarantine Act*, the *Public Works Health*

Act, the *Leprosy Act*, the *Proprietary or Patent Medicine Act* and *The National Physical Fitness Act* and of all orders and regulations passed or made under any of the said Acts;

(h) subject to the provisions of the *Statistics Act*, the collection, publication and distribution of information relating to the public health, improved sanitation and social and industrial conditions affecting the health and lives of the people;

(i) co-operation with provincial authorities with a view to the co-ordination of efforts made or proposed for preserving and improving the public health and providing for the social security and welfare of the people of Canada.

8. Nothing in this Act or in any regulations made hereunder shall authorize the Minister or any officer of the Department to exercise any jurisdiction or control over any provincial or municipal board of health or other health authority operating under the laws of any province.

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PUBLICATIONS:

(1) "Birth to Boom to Bust: Building in Calgary, 1875-1914" in *Frontier Calgary*, edited by A. W. Rasporich and H. C. Klassen. Calgary: McClelland and Stewart West, 1975.

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